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(71) Applicant *(for all designated States except US)*: **SYNECOR, LLC** [US/US]; 3908 Patriot Drive, Suite 170, Durham, NC 27703 (US).

(72) Inventors; and

(75) Inventors/Applicants *(for US only)*: **WILLIAMS, Michael, S.** [US/US]; 6793 St. Helena Road, Santa Rosa, CA 95404 (US). **FIFER, Daniel, W.** [US/US]; 382 Graciela Drive, Windsor, CA 95492 (US). **ORTH, Geoffrey, A.** [US/US]; 5800 Lone Pine Road, Sebastopol, CA 95472 (US). **SMITH, Jeffrey, A.** [US/US]; 330 Keller Street, Petaluma, CA 94952 (US). **GLENN, Richard, A.** [US/US]; 308 Westside Drive, Chapel Hill, NC 27516 (US). **ATHAS, William, L.** [US/US]; 81607 Alexander, Chapel Hill, NC 27517 (US). **STACK, Richard, S.** [US/US]; 106 Alder Place, Chapel Hill, NC 27514 (US).

(74) Agents: **FROST, Kathleen, A.** et al.; STALLMAN & POLLOCK LLP, 353 Sacramento Street, Suite 2200, San Francisco, CA 94111 (US).

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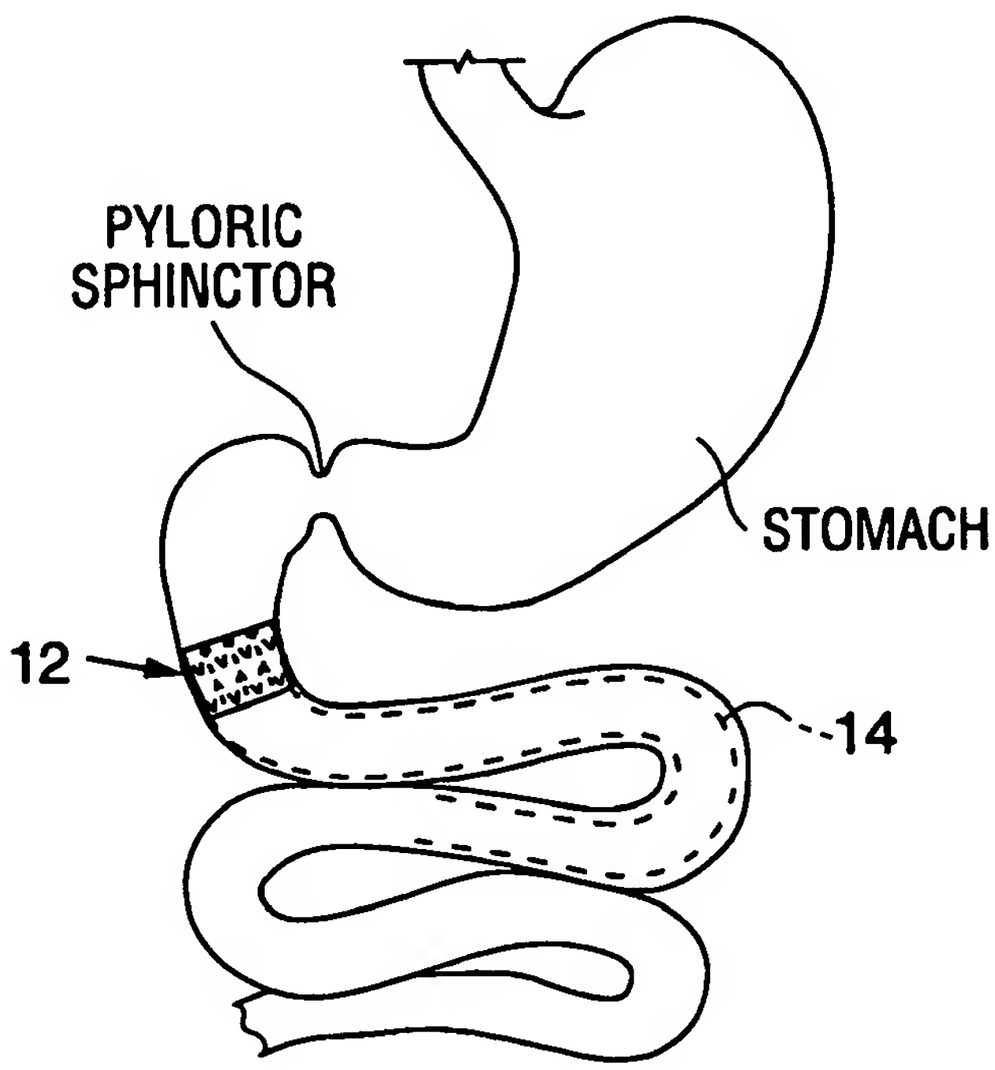

(57) Abstract: An intestinal implant includes a proximal anchor self-expandable from a radially compressed position to a radially expandable position for engagement with a wall of the intestinal lumen and a flexible sleeve coupled to the anchor. The sleeve is implanted with the anchor downstream from the pylorus and the sleeve extending further downstream through the intestinal lumen.

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INTESTINAL SLEEVES AND ASSOCIATED DEPLOYMENT SYSTEMS AND METHODS

FIELD OF THE INVENTION

The present invention relates to the field of implants for inducing weight loss in obese patients and/or treating Type II diabetes. More particularly, the invention relates to systems for implanting sleeves used to restrict intestinal absorption of ingested food and/or to regulate hormone release.

BACKGROUND OF THE INVENTION

An anatomical view of a human stomach S and associated features is shown in Fig. 27. The esophagus E delivers food from the mouth to the proximal portion of the stomach S. The z-line or gastro-esophageal junction Z is the irregularly-shaped border between the thin tissue of the esophagus and the thicker tissue of the stomach wall. The gastro-esophageal junction region G is the region encompassing the distal portion of the esophagus E, the z-line, and the proximal portion of the stomach S.

Stomach S includes a fundus F at its proximal end and an antrum A at its distal end. Antrum A feeds into the pylorus P which attaches to the duodenum D, the proximal region of the small intestine. Within the pylorus P is a sphincter that prevents backflow of food from the duodenum D into the stomach. The middle region of the small intestine, positioned distally of the duodenum D, is the jejunum J.

When food is placed in the mouth, carbohydrates in the food are partially broken down by enzymes in saliva. After the food is swallowed it is turned to a liquefied mass (chyme) by the acids and enzymes within the stomach. The chyme moves from the stomach into the intestine, where the chyme is further digested and where the bulk of the nutrients are absorbed through the intestinal membranes into the circulatory system. Within the small intestine, nutrients are broken down by enzymes and secretions from the pancreas, liver, gallbladder, as well as those secreted by cells of the intestine. The intestinal walls are lined with villi - small projections that extend into the intestinal lumen. The presence of the villi facilitates absorption by increasing the surface area of the small intestine. Undigested chyme passes into the large intestine (colon), from which

it is ultimately excreted.

Prior patents and applications assigned to the assignee of the present application disclose the use of elongated intestinal sleeves or tubes for inducing weight loss. For example, U.S. Patent No. 6,675,809 entitled "Satiation Device and Methods" describes, among other things, a tube that may be positioned beyond the pyloris, such as in or near the duodenum. Post-pyloric sleeves of this type can be useful for preventing or limiting absorption of nutrients by the small intestine, thus triggering weight loss in the patient. Moreover, it has been reported that gastric bypass procedures in which a portion of the small intestine is bypassed can ameliorate Type 2 diabetes. F. Rubino et al, The Mechanism of Diabetes Control After Gastrointestinal Bypass Surgery Reveals a Role of the Proximal Small Intestine in the Pathophysiology of Type 2 Diabetes, Annals of Surgery, Vol. 243, Number 6, June 2006. Positioning a bypass sleeve of the type disclosed in the '809 patent in the small intestine of a patient can achieve the same therapeutic function in a much less invasive manner.

BRIEF DESCRIPTION OF THE DRAWINGS

Fig. 1A is an elevation view of an example of a post-pyloric sleeve.

Fig. 1B schematically illustrates the post-pyloric sleeve of Fig. 1A within the small intestine.

Fig. 1C illustrates an expanding feature that may be provided on the distal end of the sleeve of Fig. 1A.

Fig. 1D illustrates external wall features that may be provided on the sleeve of Fig. 1A.

Figs. 2A – 2C are cross-sectional side views illustrating one embodiment of a method for deploying an inverted post-pyloric sleeve in the small intestine of a patient.

Figs. 2D and 2E illustrate a method for retrieving the sleeve deployed in Figs. 2A – 2C.

Fig. 3A is a perspective view of an inverted post-pyloric sleeve, illustrating features for retaining the sleeve on a deployment tube. The outer sleeve is shown cut away to allow the inner sleeve, anchor, and tabs to be viewed.

Fig. 3B is a perspective view of the sleeve of Fig. 3A deployed and separated from the deployment tube.

Fig. 3C is a perspective view illustrating a method of collapsing the sleeve of Fig.

3A for withdrawal from the intestine.

Fig. 4 illustrates an alternative method for deploying an inverted sleeve using an independent anchor.

Fig. 5 is a cross-sectional side view illustrating deployment of the sleeve of Fig. 4.

Figs. 6A and 6B illustrate deployment of the distal end of a sleeve and release of the sealing ring.

Fig. 6C is similar to Fig. 6A but shows a different arrangement for the distal end of the sleeve.

Figs. 7A and 7B illustrate steps for folding a distal end of a sleeve to create a seal.

Fig. 8 illustrates a sleeve folded in a star pattern.

Figs. 9A and 9B are examples of folding jigs that may be used to create a star pattern similar to that shown in Fig. 8.

Fig. 9C is a side elevation view showing a sleeve being inverted, passed into the jib of Fig. 9B for folding, and being drawn in its folded state into a deployment sleeve.

Fig. 10A is an example of a post-pyloric sleeve configured for peristaltic deployment.

Fig. 10B illustrates the sleeve of Fig. 10A in a deployment sheath together with a pusher rod.

Fig. 10C is a perspective view showing the pusher rod of Fig. 10B.

Fig. 10D illustrates the sleeve of Fig. 10A with the anchor deployed and the sleeve in the process of deploying via peristalsis.

Fig. 11A is a plan view of an alternative sleeve having features for peristaltic deployment.

Fig. 11B illustrates the sleeve of Fig. 11A deployed in the small intestine.

Fig. 12 illustrates deployment of a post-pyloric sleeve using fluid pressure.

Fig. 13 schematically illustrates sealing of the pyloric sphincter using the pyloric seal of Fig. 12.

Fig. 14A illustrates a post-pyloric sleeve carried by an alternative deployment system utilizing a capsule or cassette for containing the sleeve.

Fig. 14B shows an alternative to the cassette of Fig. 14A shaped to facilitate fluid propulsion of the cassette within the intestine.

Fig. 15A illustrates rolling of a post-pyloric sleeve into a cassette for deployment.

Figs. 15B and 15C are a perspective view and a cross-sectional side view of the

cassette of Fig. 15A.

Fig. 16 illustrates a post-pyloric sheath in a compressed position and carried by a deployment catheter.

Figs. 17 and 18 illustrate a fluid-advanceable device for carrying a post-pyloric sleeve through the small intestine.

Fig. 19 illustrates an alternative fluid-advanceable device passing through an intestinal lumen.

Figs. 20 and 21 show a modification to the system of Fig. 19, in which Fig. 20 shows the system collapsed within a tube for delivery into the stomach and through the pylorus, and Fig. 21 shows the system released from the tube.

Figs. 22A – 22D illustrate use of an alternative embodiment of a fluid deployable device for carrying a post-pyloric sleeve through the small intestine.

Figs. 23A and 23B are perspective views showing a device similar to the Fig. 22A device modified to include a valve.

Figs. 24A – 24C illustrate a system for deploying a guide wire through an intestinal lumen.

Figs. 25A – 25C illustrate a modification to the system of Fig. 24A-C for use in deploying an intestinal sleeve.

Fig. 26A illustrates a torquable catheter system for use in moving a guidewire through an intestinal tract.

Fig. 26B is a side elevation view of a distal end of a guidewire.

Fig. 27 is a schematic illustration of a human stomach and a portion of the small intestine.

DETAILED DESCRIPTION

This application describes intestinal sleeves, preferably anchored in the gastrointestinal track downstream of the pylorus, that are suitable for minimizing absorption of ingested materials including sugars, by the intestine, thus inducing weight loss and treating Type II diabetes.

Fig. 1A shows an example of a post-pyloric implant 10. Implant 10 includes an anchor 12 and an elongate flexible sleeve 14. The anchor 12 includes structural features that allow the anchor to be compressed to a small diameter for passage through the

pylorus and into the small intestine, and then radially self-expanded into engagement with the wall of the intestinal lumen. Anchors constructed of mesh, bands or other structural frameworks using shape memory elements (e.g. nickel titanium alloy, nitinol or shape memory polymer) or stainless steel, Eligoy, or MP35N wires or structures may be used.

Sleeve 14 is preferably a flexible tube having a length chosen to limit absorption of nutrients by the small intestine. Exemplary devices may have lengths on the order of 10 – 200 cm, although longer or shorter devices might be suitable for certain patients. Materials suitable for use include ePTFE, polyurethane, microporous polyurethane, polyester, polyethylene and other comparable materials. The sleeve may be comprised of more than one material, for example the polymeric material may be reinforced with a metallic or polymeric braid or coil, or a braid or woven sleeve might include a polyurethane coating. In one embodiment, an ePTFE sleeve includes an elastomeric outer surface. A sleeve having this configuration can dwell in a partially collapsed state within the intestine, and then radially expand as food is driven through it by peristalsis. With this construction, the sleeve can resist twisting, kinking or collapse. It may also allow for passage of digestive enzymes along the exterior of the sleeve, and it can also facilitate deployment by natural means such as peristalsis if desired.

The materials or material properties of the sleeve may vary along the length of the sleeve. The inner and/or outer walls might be coated, treated or impregnated with any number of materials, coatings, or compositions, including hydrophilic coatings to enhance the lubricity of the sleeve, antimicrobial coatings, compositions that will regulate hormone production, etc. The sleeve may be non-porous, porous, or porous at certain locations. Openings may be positioned on the sleeve at select locations, such as at a location corresponding to the location of the common bile duct within the small intestine. As shown in Fig. 1C, the distal end of the sleeve 14 may include an embedded feature such as elastomeric scaffold 16 to facilitate opening of the distal end of the sleeve 14 to prevent obstruction. As illustrated in Fig. 1D, the exterior surface of the sleeve may include features 18 or a coating that allows the intestinal wall to lightly engage the sleeve, such as for preventing migration of the sleeve towards the stomach. These features might include nodules, barbs, spikes, dimples or other elements that provide texture to the sleeve.

Various methods for deploying an implant such as the implant 10 will next be described. For many of the disclosed methods, a deployment system is advanced through

the pyloric sphincter and then used to deploy the sleeve with the anchor in a post-pyloric location and the sleeve extending distally of the anchor. These embodiments may be modified to position the anchor within the antrum or other parts of the stomach, with the sleeve passing through the pylorus into the stomach.

The anchor position is preferably selected to avoid obstruction of the bile-releasing function of the ampulla of vader, although the construction of the anchor might be such as to allow its placement over the ampulla without interference with the ampulla's function. In preferred methods, the deployment system is introduced into the body via the oral cavity, passed through the esophagus and into the stomach, and then moved through the pyloric sphincter into the small intestine. In alternative methods, the deployment system may be advanced into the stomach using a small perforation through the abdominal wall and into the stomach, and then passed into the small intestine from the stomach.

One example of a deployment method, shown in Figs. 2A – 2C, uses an outer sheath 20 axially positioned over an inner sheath 22. The outer sheath 20 extends distally from the inner sheath 22, leaving room for the anchor 12 of the post-pyloric sleeve 10 to be contained in a collapsed position within the distal end 24 of the outer sheath 20. The sleeve 14 is positioned within the inner sheath 22, extending in a proximal direction as shown, and is inverted such that its inner surface faces outwardly. Sleeve 14 may be singly inverted, such that its distal end (meaning the end that is positioned furthest along the intestine from the stomach once the sleeve is fully deployed) is in the most proximal position for deployment, or it may be inverted multiple times within its lumen. An optional seal 26 on the inner sheath 22 is in sealing contact with the sleeve 14.

With the distal end of the outer sheath 20 positioned in the small intestine, fluid such as water or gas is directed through the inner sheath 22 as shown in Fig. 2B. The fluid exerts pressure against the inverted sleeve 14, causing the sleeve to evert through the anchor 12 until the full length of the tube has deployed. As the sleeve is deployed, the inner and outer sheaths 20, 22 preferably remain in a fixed position, allowing the sleeve to roll out of the inner sheath into the intestinal lumen without sliding relative to the surface of the intestinal wall. Once the sleeve is deployed, the outer sheath 20 is withdrawn, causing the anchor 12 to pass out of the sheath 20 and to self-expand into engagement with the intestinal wall. If preferred, the anchor 12 may alternatively be deployed before the sleeve is everted.

Removal of the implant 10 from the intestine is achieved by engaging a portion (e.g. the distal end, or a more proximal or intermediate portion) of the sleeve 14 such as by advancing a grasping instrument through the sleeve 14 and engaging the sleeve with the grasping instrument. The engaged portion of the sleeve is pulled through the sleeve's inner lumen as shown in Fig. 2D causing the sleeve 14 to invert and to pass into a capture tube 28. The capture tube 28 is advanced over the grasping instrument to a position near the anchor 12, and traction is applied to the sleeve 14 as shown in Fig. 2E to draw the anchor 12 into a collapsed position within the capture tube.

As illustrated in Figs. 3A and 3B, the implant may include a plurality of tabs 30 (on the sleeve 14 or the anchor 12) that engage with the inner sheath 22, preferably forming a seal. Once the implant 10 is deployed as shown in Fig. 3B, the tabs 30 may remain on the implant, or they may bioerode or be removed in another way. If the tabs 30 remain in place, they might be later be cinched together using a strand of suture 32 as in Fig. 3C and used to withdraw the implant 10 into a capture tube (not shown).

In alternate implant designs, the sleeve 14 and anchor may be separate components as shown in Fig. 4. A system for deploying this modified implant includes an outer sheath 20 having the proximal end of the sleeve 14 mounted to its distal end 24 and inverted to extend through the lumen of the sheath 20. As shown in Fig. 5, fluid is used to evert the sleeve 14 in a manner similar to that described above. Referring again to Fig. 4, once the sleeve 14 has been positioned in the intestine, an inner sheath 22 having anchor 12 collapsed within it is advanced to the proximal end of the sleeve 14. An anchor pusher 34 is used to push the anchor from the inner sheath 22, causing the anchor to expand and to trap the proximal end of the sleeve between the anchor and the intestinal wall.

Fig. 6A illustrates an implant 10 in the inverted position in the process of being deployed. As shown, sealing the distal end 36 of the sleeve 14 can facilitate deployment as fluid pressure everts the sleeve. The distal end of the sleeve may be bunched, folded, twisted, rolled or simply compressed, and its position retained by an optional clamping device 38 such as an o-ring, staple, clip, suture etc. which will release from the sleeve upon full deployment as shown in Fig. 6B. The clamping device 38 may be bioerodable or constructed to be small enough to pass through the intestinal tract. Dissolvable or temporary adhesives or other agents may be used with, or as an alternative to, the clamping device 38. As yet another alternative shown in Figs. 7A and 7B, a fold 40 can

be placed in the distal end 36 of the sleeve, and then a Z-fold 42 formed to seal the distal end 36.

In a preferred arrangement, the clamping device is an o-ring anchored to the sleeve 14 by friction caused by an interference or compression fit. The everting pressure acts upon the interface after the sleeve has fully everted (Fig. 6B), preventing an unintended pressure loss or failure to deploy. The o-ring is proportioned to readily pass through the digestive system after it detaches from the sleeve. Fig. 6C is similar to Fig. 6A but shows a different arrangement for the distal end of the sleeve prior to release of the o-ring 38.

In some embodiments, it may be useful to pleat the sleeve 14 with controlled, longitudinal folds, such as those forming a star-shaped or other symmetrical cross-section as shown in Fig. 8 so as to minimize binding of the sleeve 14 as it everts during deployment. This type of folding pattern can be facilitated by threading the sleeve through a jig 44a, 44b of the type shown in Figs. 9A and 9B. The jig 44a, 44b includes an opening 46 and slits 48 radiating from the opening 46. Threading the sleeve through one of the jigs causes the sleeve to fold into a star-shaped pattern. Preferably, the sleeve is fed directly from the jig into a retention sheath to retain the folded pattern. For example, as shown in Fig. 9C, as the sleeve 14 is being inverted and loaded into sheath 22, its distal end is drawn into its own interior lumen, pulled through the lumen of the anchor 12, into the jig 44b to place the folds/pleats in the sleeve 14, and pulled further (now folded/pleated) into the sheath 22.

The next sequence of embodiments make use of the natural peristaltic movement of the intestine to carry the distal end of the sleeve 14 into its deployed position within the intestine. As with the previously described embodiments, use of these methods typically involves advancing the deployment system containing the implant through the pylorus and then deploying the sleeve and anchor using the deployment system. With each of these embodiments, the anchor may be engaged with the intestinal wall either prior to or after deployment of the sleeve.

A peristaltically deployed implant may be similar to the implant 10 of Fig. 1A, but it preferably includes a weighted element capable of being engaged by the peristaltic action of the intestine such that it will be carried by peristalsis through the intestine. The element is selected to be one having a mass or size that allows it to be better engaged by peristaltic activity than the sleeve material itself.

Referring to Fig. 10A, implant 10a may be modified to include an o-ring 50 on its distal end. O-ring 50 may be formed of any suitable material. In one embodiment, it may be thick silicone rubber or another non-degradable material, or it may be a material that bioerodes or dissolves over time. The o-ring might be anchored to the sleeve 14a such that it will remain in place until the sleeve is removed from the body, or it can be temporarily attached to the sleeve (e.g. using dissolvable adhesives or sutures) so that it will detach from the sleeve following deployment and pass through the digestive system. The o-ring 50 can include radiopaque markers 52 such as platinum tubes crimped onto the o-ring.

Other embodiments for deploying the sleeve using peristalsis may include packaging the implant in a tear-away sheath, advancing the packaged sheath beyond the pylorus, and removing the sheath (e.g. using a pullwire). Another embodiment shown in Fig. 16 employs a lead tube 76 having an atraumatic tip 78 of sufficient size and mass to be carried through the intestine by peristalsis. Lead tube 76 is coupled to the distal end of the sleeve 14 by an o-ring 80 or other temporary means. Both the lead tube 76 and the o-ring 78 may be bioerodible or passable from the system. As with the other disclosed embodiments, this system can be used to move the sleeve through the intestine either before or after the anchor 12 is engaged with the intestinal wall.

Referring to Fig. 10B, a deployment system for the implant 10a of Fig. 10A may include a sheath 54 having the implant 10a within it. The sleeve 14a of the implant 10a may be accordion pleated within the sheath 54 as shown, or it may be simple crumpled into the sheath, or folded in some other way. Pleating may be in a uniform pattern, or different parts of the sleeve may be more tightly or loosely pleated to encourage deployment. During use, the sheath 54 as assembled in Fig. 10B is preferably passed over a guidewire 56 that has been guided through the pyloric sphincter. The sheath 54 is positioned with its distal end positioned past the pyloric sphincter, and a push rod 58 is used to push the implant 10a such that at least part of the sleeve 14a exits the sheath 54. During this step of deployment, the push-rod may be used to cause only the distal end of the sleeve 14a to exit the sheath 54, or to cause the entire sleeve 14a but not the anchor 12a to exit the sheath 54, or to fully expel the implant 10a (including the anchor) from the sheath 54. Details of an exemplary push rod 58, which may include a lumen 60 for accommodating the guidewire and a shoulder 62 for engaging the anchor 12a, are shown in Fig. 10C.

When the o-ring 50 passes into the intestine, it is carried through the intestine by peristalsis, gradually expanding the sleeve 14a as shown in Fig. 10D. If the anchor 12a was not previously deployed, the push rod 58 may be subsequently used to release the anchor during or after full deployment of the sleeve 14a.

With respect to embodiments whose deployment is achieved using peristalsis, airds may be employed to enhance or increase natural peristalsis to facilitate deployment. For example, in the system shown in Fig. 10B, guidewire 56 may function as a stimulating lead having an electrode that may be energized when placed into contact with tissue at selected regions of the intestine or stomach so as to regulate peristaltic contractions. Alternatively, guidewire 56 may include a delivery lumen for delivering agents suitable for enhancing peristalsis. In either case, a separate electrode lead or fluid delivery lumen, rather than the guidewire, may be used to regulate peristalsis.

Figs. 11A and 11B illustrate an alternative implant 10b in which the o-ring of Fig. 10A is replaced with a dissolvable member 64 such as a dissolvable/erodible gelatin capsule tethered to the distal end 36 of the sleeve 14b. Deployment of the Fig. 11A may proceed as described in connection with the Fig. 10A embodiment.

In an alternative deployment method shown in Fig. 12, a deployment sheath 66 containing the implant 10 is passed through the pylorus. The sleeve 14 of the implant is accordion folded within the sheath 66, and the implant is sealed using an o-ring or other seal 38 (see those described in connection with Figs. 6A – 7B) at the distal end of the sleeve 14. Water or other suitable fluid is directed into the sheath 66 and through the implant 10. The fluid pressure within the sealed sleeve 14 causes the sleeve to unfold within the intestine. Once the sleeve is fully deployed, the seal 38 is released. As best illustrated in Fig. 13, the sheath 66 may include an annular balloon 68 expandable beyond the pylorus to seal the pylorus against backflow of water. A push rod 58 may be used to expel the anchor 12 from the sheath 66 either before or after the sleeve is deployed.

In a variation of the Fig. 12 embodiment shown in Fig. 14A, the sleeve 14 may be folded, compressed or rolled to fit into a capsule or cassette 70 positioned distally of a sheath 66 housing the compressed the anchor 12. The capsule 70 is advanced by peristalsis or by fluid pressure (Fig. 14B), allowing the sleeve to pay out from the capsule as it advances within the intestine. Once the sleeve is deployed, the capsule detaches from the sleeve and passes from the body. Fig. 15A illustrates that the sleeve can be rolled into the capsule by engaging the sleeve with a mandrel 72 and rotating the mandrel

about its longitudinal axis. As more easily seen in Figs. 15B and 15C, capsule 70 includes holes 74 for receiving the mandrel.

Figs. 17 through 23B illustrate the use of fluid to propel an expandable component through the intestine. In these embodiments, a guidewire may be tethered to the expandable component so that the sleeve 14 may later be passed over the guidewire, or the sleeve itself may be tethered to the expandable component. As shown in Figs. 17 and 18, the expandable component may take the form of a shuttlecock 82 having an atraumatic tip 84. A plurality of struts 86 are hinged to the tip 84, and webbing extends between the struts. When released from the constrained position shown in Fig. 17, the struts 86 spring to the expanded position shown in Fig. 18, expanding the webbing 88 into a conical shape. Fluid directed as shown in Fig. 18 will impart pressure against the interior of the expanded cone, causing the expandable component 82 to advance through the intestine. In alternative configurations, the expandable component may have a parachute type configuration 88 that is expandable as a result of fluid pressure as shown in Figs. 19 – 21. In another embodiment, the expandable component may be an inflatable balloon 90 that is expanded within the intestinal lumen and then propelled within the intestine by fluid pressure as shown in Fig. 22C. This design may be modified to include a flap valve 92 as shown in Fig. 23A and 23B. As water is pulsed towards the balloon 90 to advance it within the intestine, the water contacts the flap valve 92 to propel the balloon. In between pressure pulses of the fluid system, the flap 92 will open as in Fig. 23B if necessary to relieve backpressure within the intestine.

As discussed in connection with Fig. 10B, some implantation methods may be performed by tracking the sleeve over a guidewire alone or in combination with other deployment methods. Figs. 24A – 26 illustrate and describe methods that may be used to manipulate a guidewire through the intestines

Referring to Fig. 24, guidewire 56 extends through a catheter 100 having an inflatable balloon 102 at the distal end. To deploy the guidewire, the catheter 100 is moved into the intestine and the balloon 102 is inflated into contact with the surrounding intestinal walls. The guidewire is passed though the catheter until it extends from the distal end of the catheter 100. The balloon is next deflated, the catheter advanced further within the intestine, the guidewire advanced, etc. until the guidewire reaches the desired location in the intestine (e.g. beyond the pylorus). The catheter may include an optional anchoring balloon 104 (shown in dashed lines in Fig. 24C) that is inflatable to anchor the

wire in place within the intestine as the catheter is advanced over the wire. In alternative guidewire placement methods, a balloon of this type may be used to carry the guidewire through the intestine using peristalisis or fluid pressure as disclosed above in connection with sleeve deployment.

Once the guidewire is in position, an intestinal sleeve 14 and anchor 12 (preferably packaged within a sheath as described) are tracked along the guidewire to the desired location in the body, at which time they may be released from the sheath and anchored within the intestine.

Figs. 25A – 25C illustrate that sequentially inflation, advancement and deflation of balloons may be used to deploy the sleeve 14 itself. For example, as shown sleeve 14 may be positioned within a sheath 106 having distal and proximal balloons 108, 110. Proximal balloons 110 is inflated into contact with the surrounding intestinal walls to prevent rearward movement of the sheath 106 while the distal section of the sheath (including deflated distal balloon 108) is advanced over the guidewire 56. Next, distal balloon 108 is inflated into contact with the surrounding walls, and proximal balloon 110 is deflated and advanced, causing the sheath 106 to inch-worm along the guidewire 56. Once in the proper position, the sheath 106 is removed from the sleeve 14 (e.g. by using a pusher to push the sleeve from the sheath as discussed above, or by perforating the sheath, etc.), causing the anchor to expand and engage the surrounding intestinal walls.

Any of the disclosed embodiments may employ an endoscope to allow visualization of the implantation procedure. The guidewire or associated instruments or implants may be passed through the working channel of a flexible endoscope, or through other access tubes passed through the mouth and esophagus. Manipulation and steering of a guidewire 56 through the tortuous intestinal system may be accomplished by passing the guidewire through one or more telescoping catheters 112a, 112b (Fig. 26A) that function to change the orientation of the catheter as it is advanced. For example, inner catheter 112a may have a pre-shaped distal end as shown that may be used to steer the guidewire, and outer catheter 112b may be a straight catheter that will retain catheter 112a in a straight orientation when the inner catheter 112a is drawn inside it. The distal end of the guidewire 56 may include a supple distal tip as shown in Fig. 26B to minimize trauma to surrounding tissue.

Any of the above implants and systems may be packaged with instructions for use setting forth methods for implanting the implants in accordance methods of the type

disclosed herein, for the purpose of inducing weight loss and/or treating diabetes by causing the implant to restrict absorption of ingested material such as carbohydrates, nutrients, etc.

It should be recognized that a number of variations of the above-identified embodiments will be obvious to one of ordinary skill in the art in view of the foregoing description. Moreover, the various features of the embodiments that have been described may be combined in various ways to produce numerous additional embodiments. Accordingly, the invention is not to be limited by those specific embodiments and methods of the present invention shown and described herein. Rather, the scope of the invention is to be defined by the following claims and their equivalents.

Any and all patents, patent applications and printed publications referred to above are incorporated by reference.

1. An implant system for use in an intestinal lumen, comprising:

a proximal anchor self-expandable from a radially compressed position to a radially expandable position for engagement with a wall of the intestinal lumen; and

a flexible sleeve coupled to the anchor.

2. The implant system of claim 1 wherein the sleeve is formed of a flexible polymeric material.

3. The implant system of claim 2 wherein the flexible polymeric material comprises ePTFE having an elastomeric outer surface.

4. The implant system of claim 1, further including a deployment sheath having a lumen, the sleeve positioned within the deployment sheath with a distal portion of the sleeve drawn in a proximal direction in parallel to an adjacent portion of the sheath, the distal portion and adjacent portion defining an annular pocket.

5. The implant system of claim 4, further including a fluid source fluidly coupled to the annular pocket to pressurize the annular pocket and evert the sleeve.

6. The implant system of claim 5 further including a seal sealing a distal end of the sleeve, the seal releasable from the distal end during eversion of the distal end of the sleeve.

7. The implant system of claim 1, further including an element on a distal portion of the sleeve, the element engageable by peristalsis to cause advancement of the distal portion within the intestinal lumen.

8. The implant system of claim 7, further including an electrode positionable in contact with the intestinal lumen, the electrode energizeable to regulate peristalsis within the lumen.

9. The implant system of claim 1, wherein a distal portion of the sleeve is positioned within a capsule, and wherein the system includes a fluid source positionable to direct a

fluid into the intestinal lumen and into contact with the capsule, the capsule advanceable through the intestinal lumen in response to pressure from the fluid.

10. The implant system of claim 9 wherein advancement of the capsule within the intestinal lumen releases the sleeve from the capsule.

11. The implant system of claim 1, further including instructions for use instructing the user to position the anchor at an anchor position downstream of a pylorus in the intestinal lumen, and to expand the anchor at the anchor position.

12. A method of positioning an intestinal sleeve, comprising:

providing an intestinal sleeve having a proximal end and a distal end;

anchoring the proximal end downstream of a pylorus in an intestinal lumen, and positioning the distal end within the intestinal lumen downstream of the proximal end.

13. The method according to claim 12, further including advancing a guidewire into the intestinal lumen, and advancing the intestinal sleeve over the guidewire.

14. The method according to claim 12, wherein positioning the distal end within the intestinal lumen downstream of the proximal end includes:

drawing a distal portion of the sleeve in a proximal direction to invert the sleeve and to form a pocket between adjacent portions of the sleeve; and

with at least a portion of the sleeve within the intestinal lumen, directing a fluid into the pocket to cause the sleeve to evert.

15. The method according to claim 14, wherein the method includes positioning the inverted sleeve within a sheath and directing the fluid through the sheath.

16. The method according to claim 14, wherein the method includes sealing a distal portion of the sleeve, and causing the seal to release from the sleeve during eversion of the sleeve.

17. The method according to claim 12, wherein positioning the distal end within the

intestinal lumen downstream of the proximal end includes positioning a detachable element on the sleeve and causing the element to be carried in a downstream direction by peristaltic movement of the intestine.

18. The method according to claim 12, wherein positioning the distal end within the intestinal lumen downstream of the proximal end includes positioning a distal portion of the sleeve within a capsule, and directing a fluid into the intestinal lumen and into contact with the capsule, such that the capsule advanced through the intestinal lumen in response to pressure from the fluid.

19. The method according to claim 17, wherein a proximal portion of the sleeve is anchored within the intestinal lumen prior to the step of directing the fluid, and wherein advancement of the capsule releases the sleeve from the capsule.

20. The method according to claim 12, wherein the method is further for treating Type II diabetes and/or inducing weight loss, and further includes the step of causing ingested material moving into the intestine to pass into the sleeve, thereby minimizing contact between the material and tissue of the intestinal lumen and minimizing absorption of calories and/or carbohydrates.

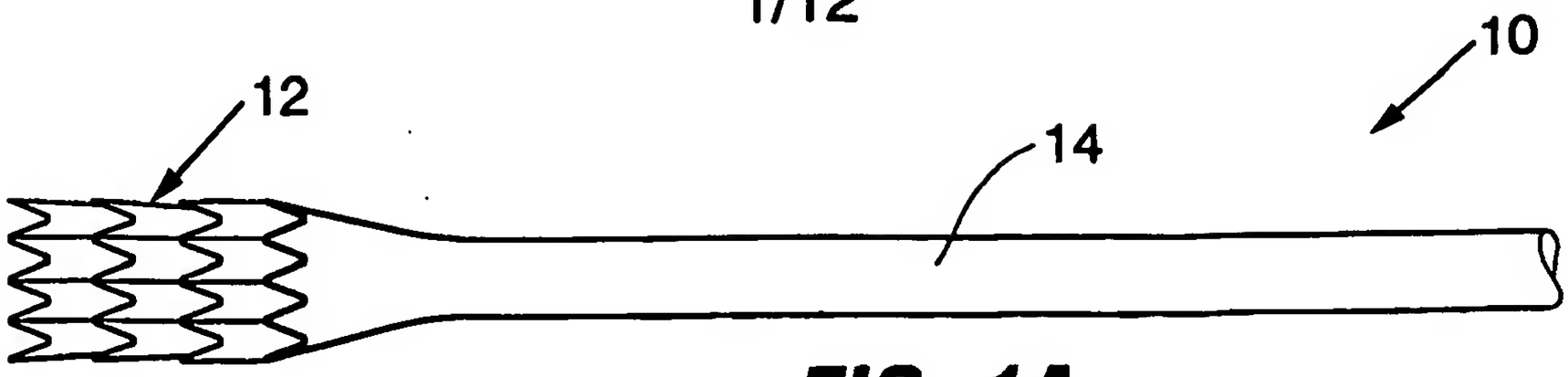

FIG. 1A

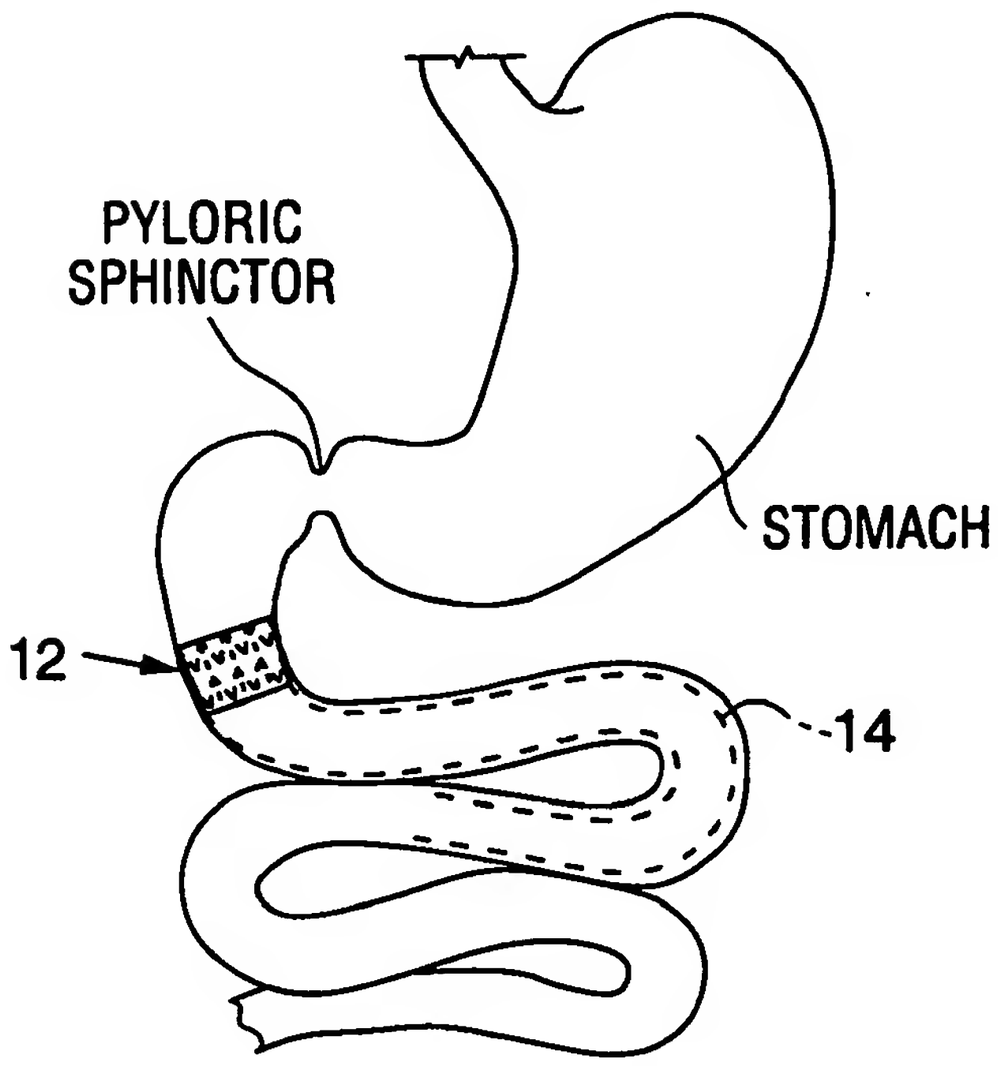

FIG. 1B

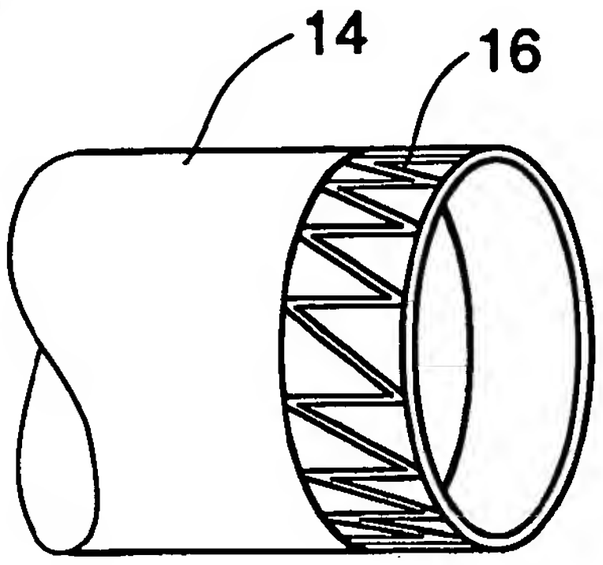

FIG. 1C

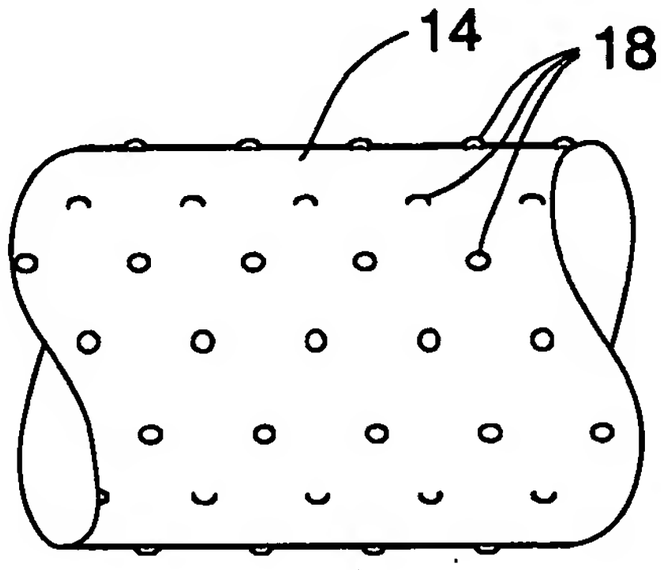

FIG. 1D

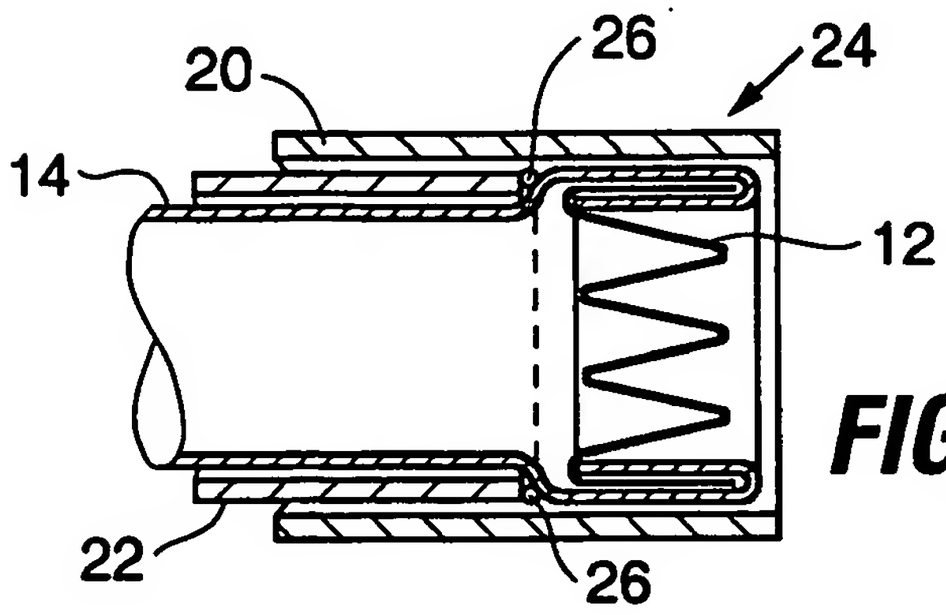

FIG. 2A

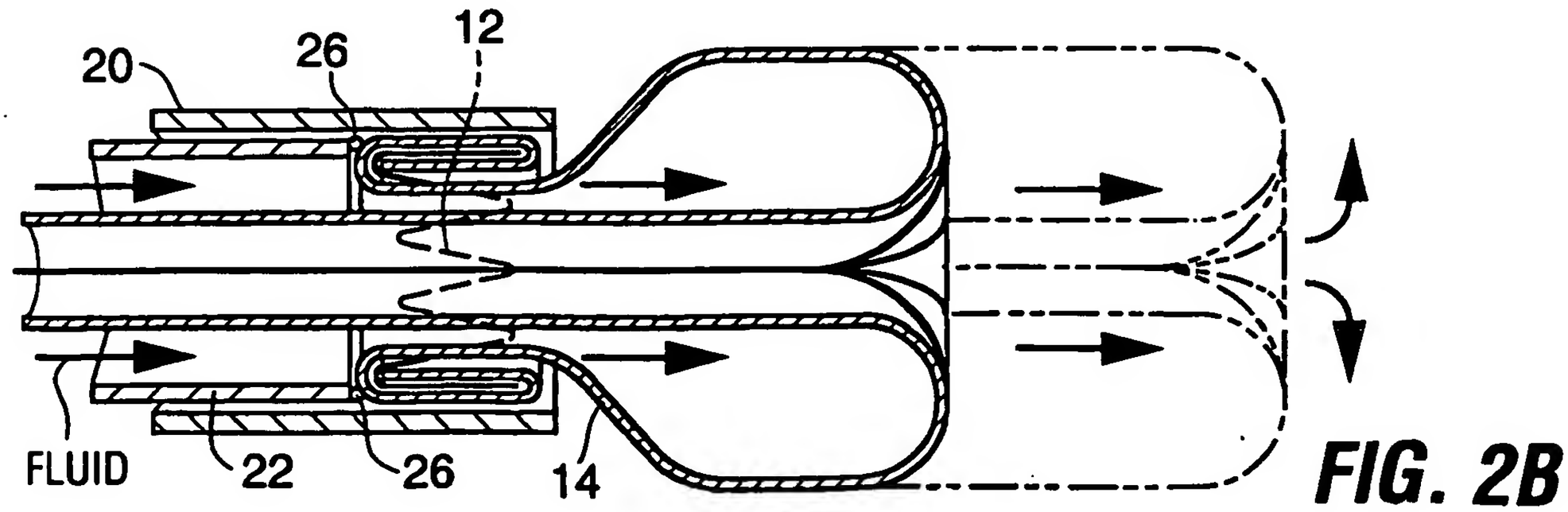

FIG. 2B

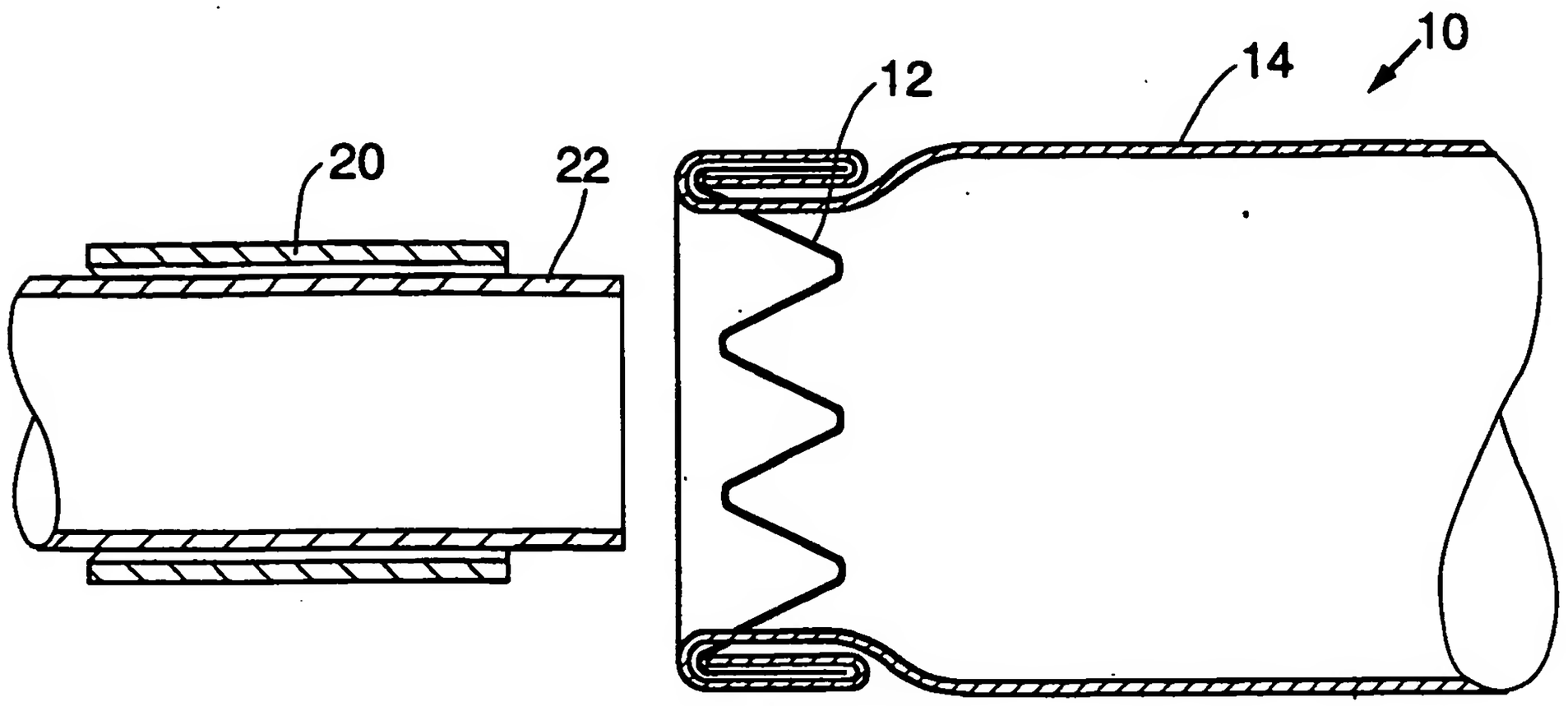

FIG. 2C

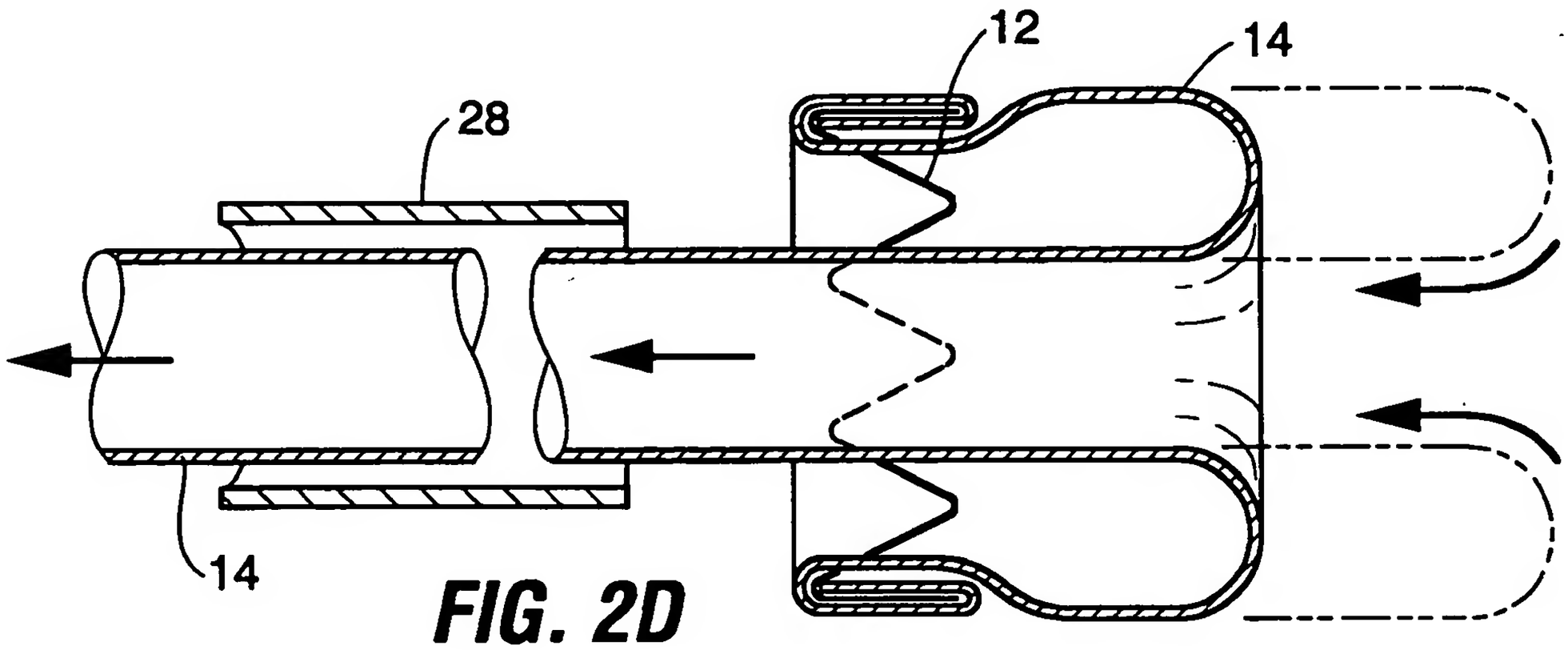

FIG. 2D

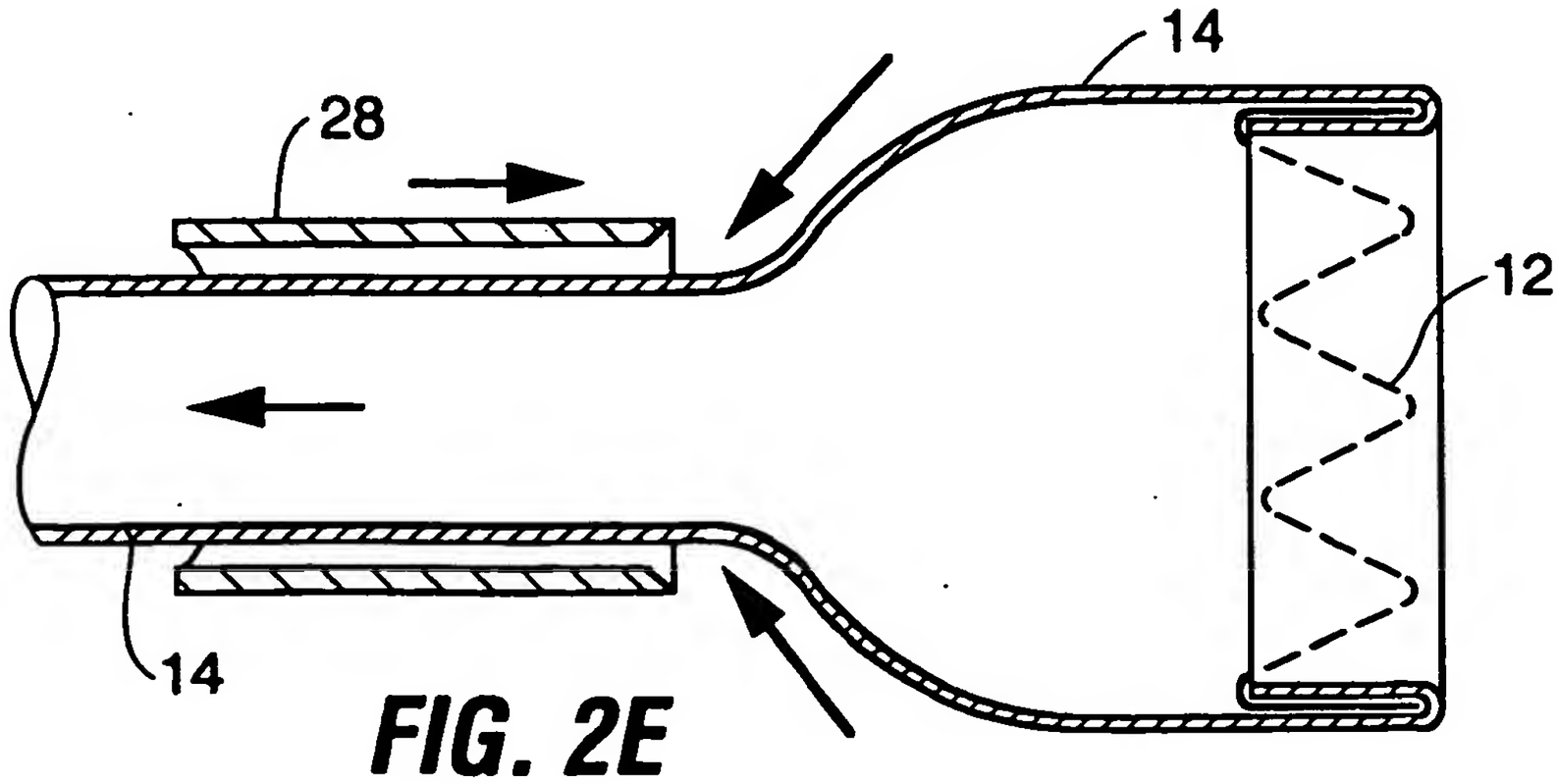

FIG. 2E

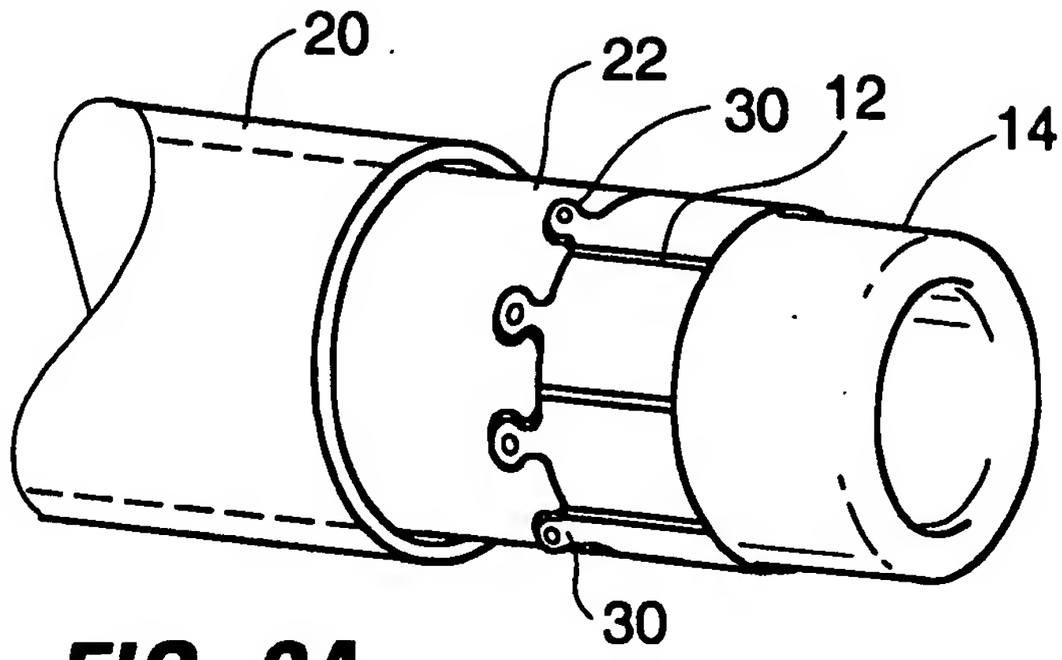

FIG. 3A

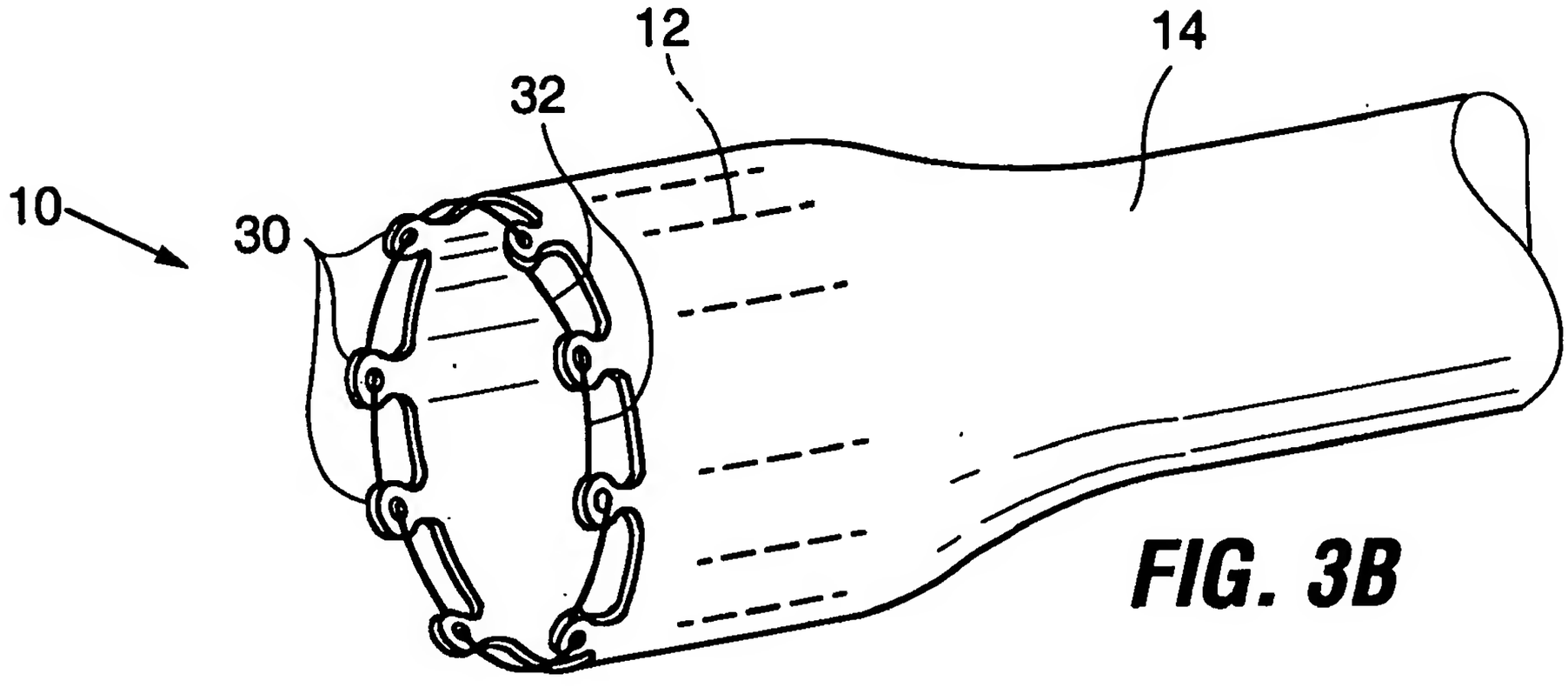

FIG. 3B

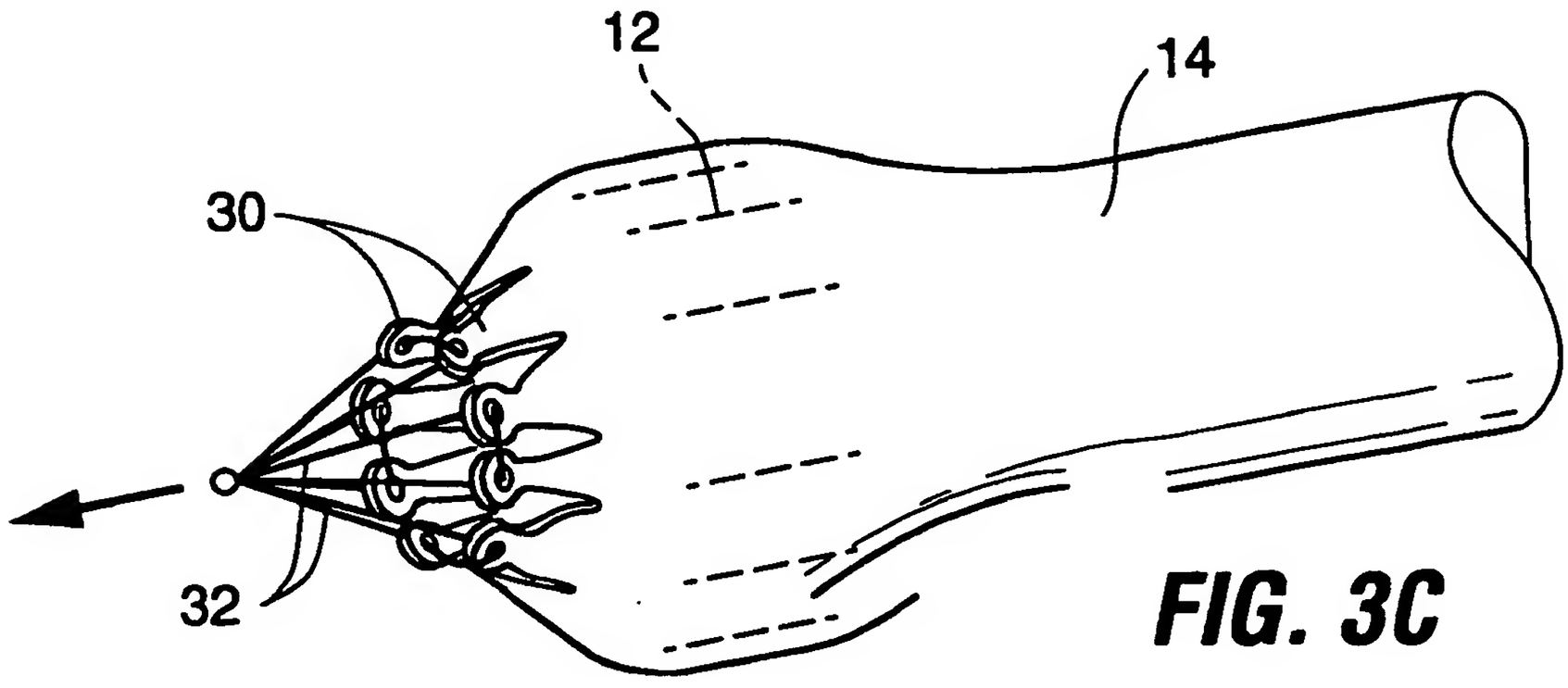

FIG. 3C

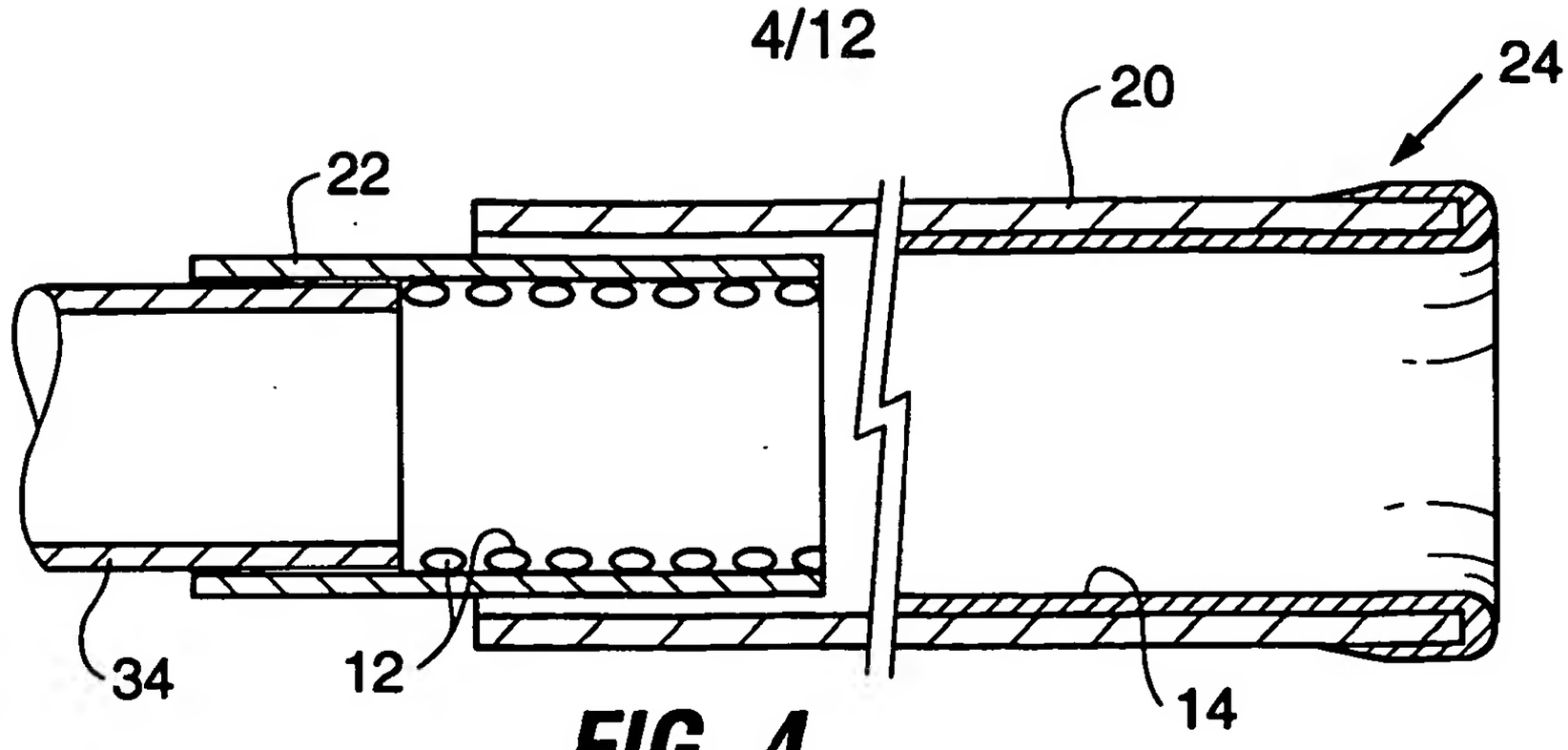

FIG. 4

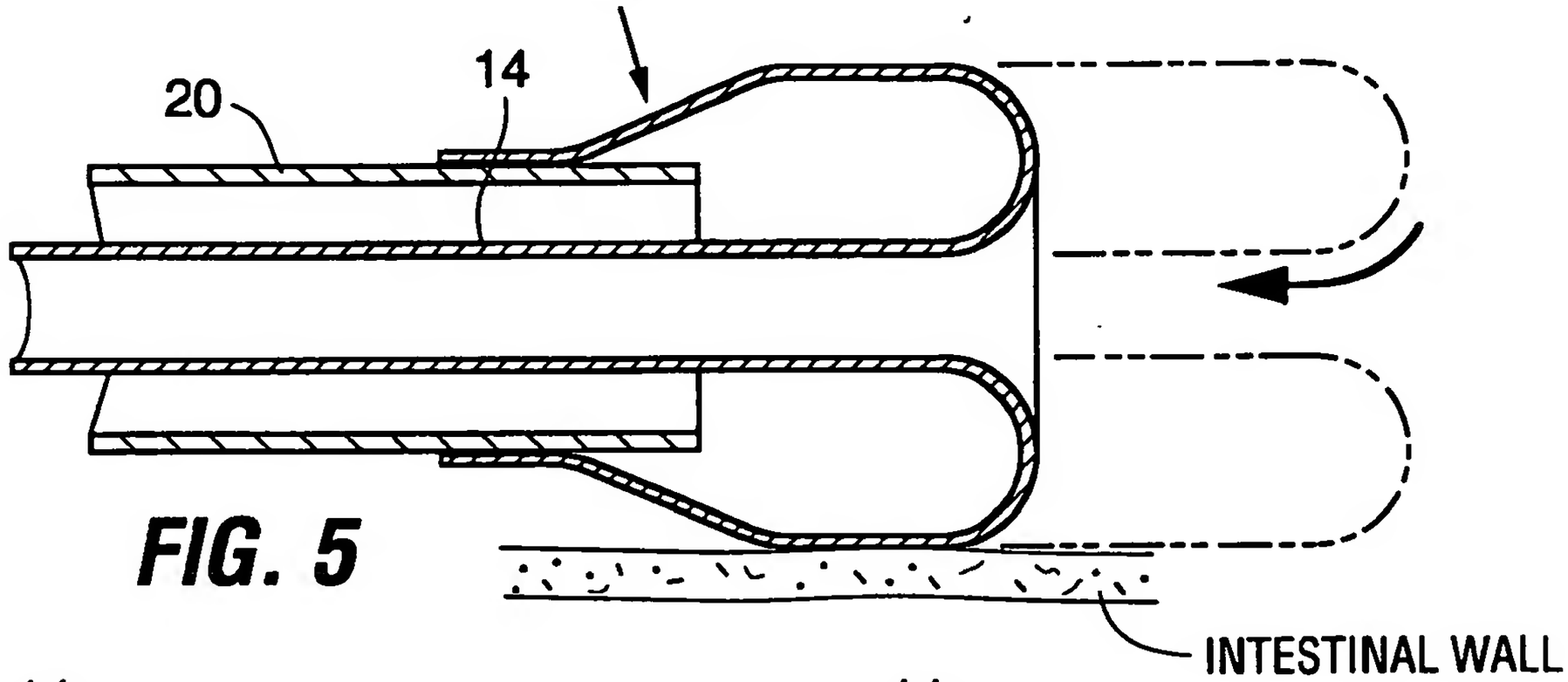

FIG. 5

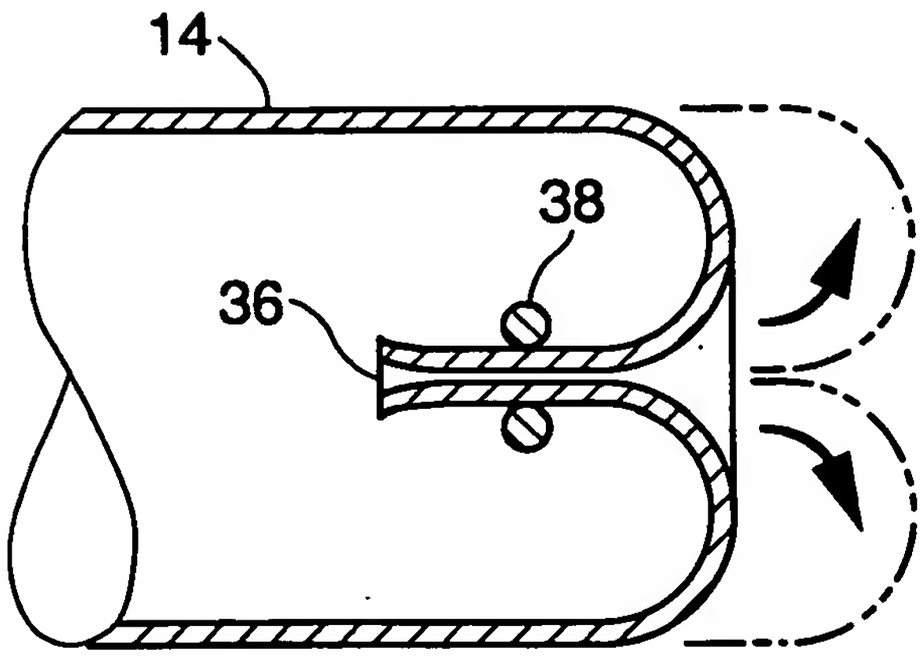

FIG. 6A

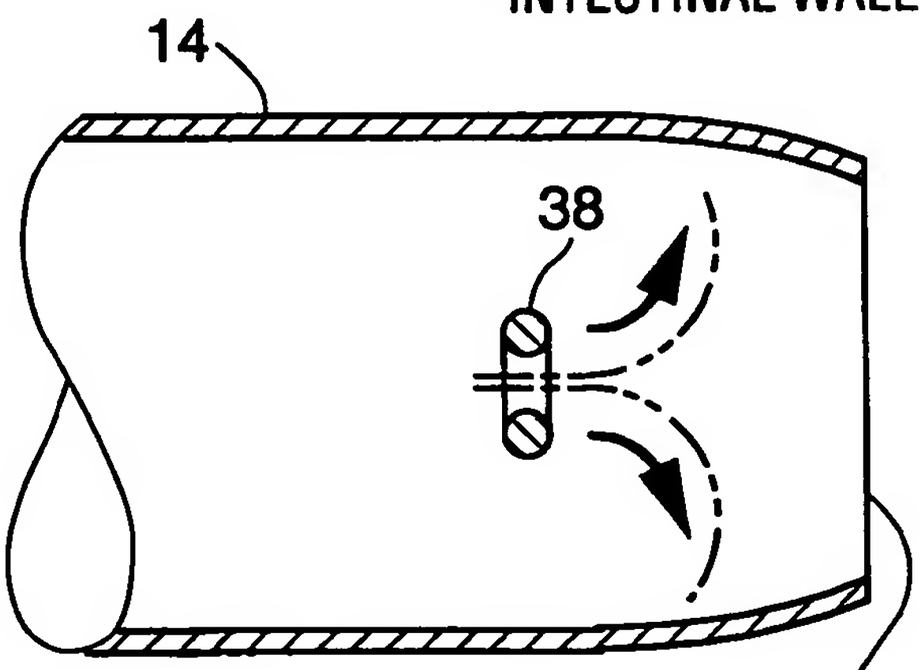

FIG. 6B

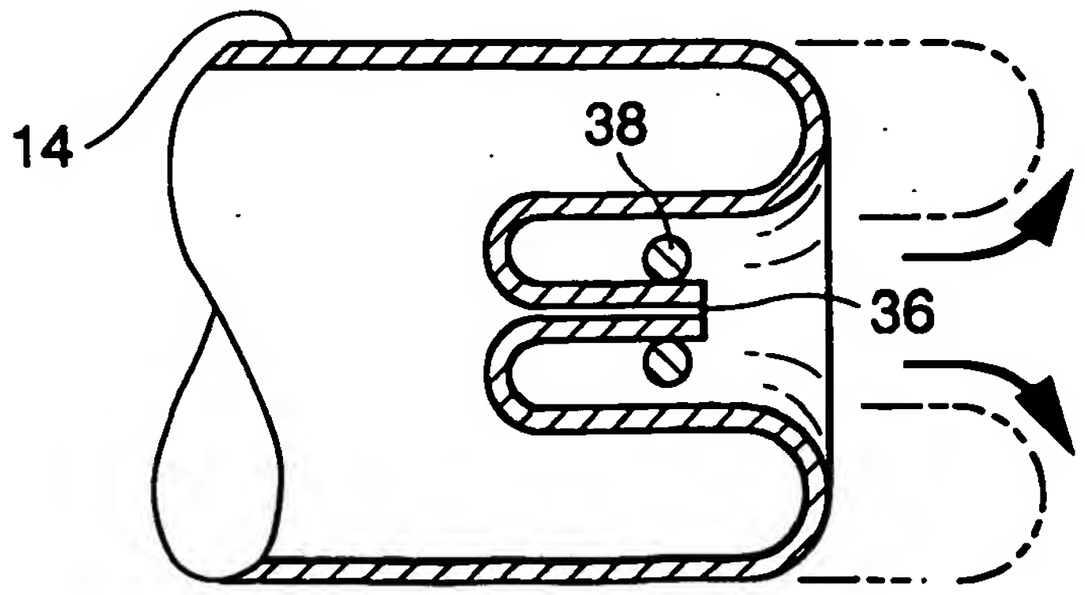

FIG. 6C

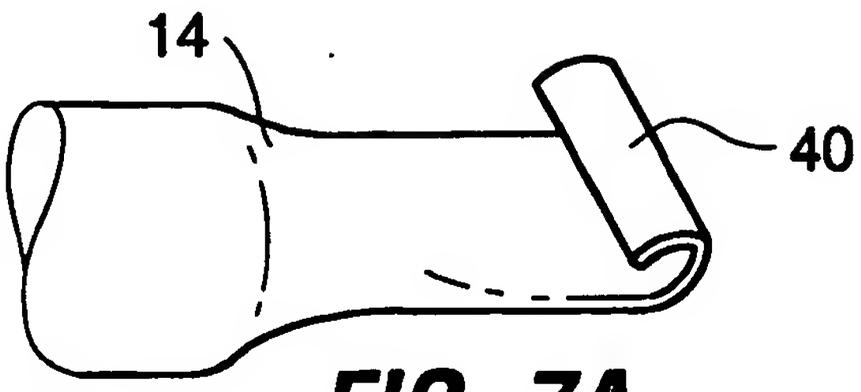

FIG. 7A

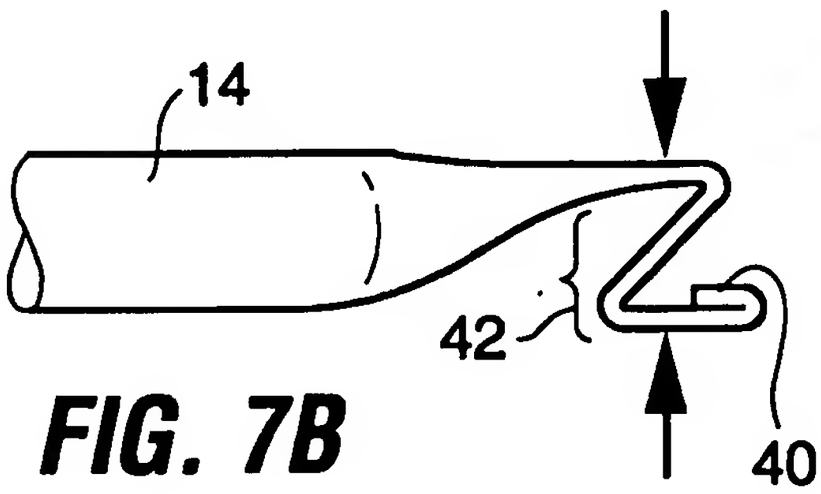

FIG. 7B

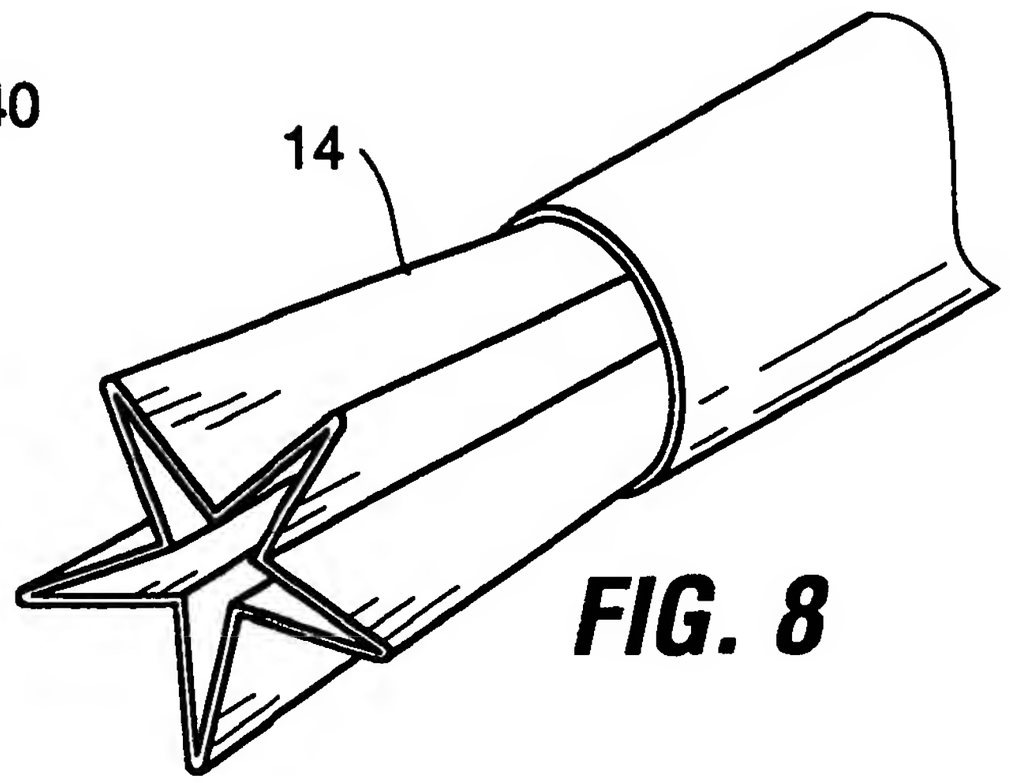

FIG. 8

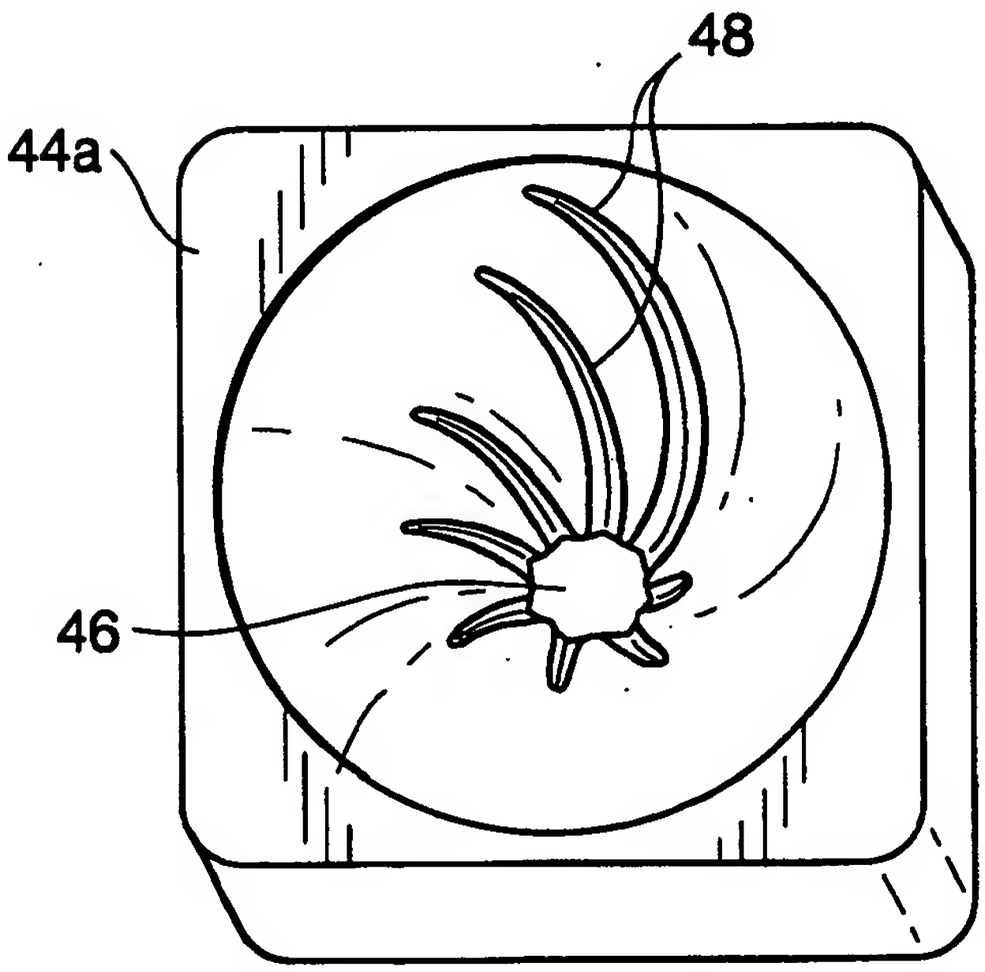

FIG. 9A

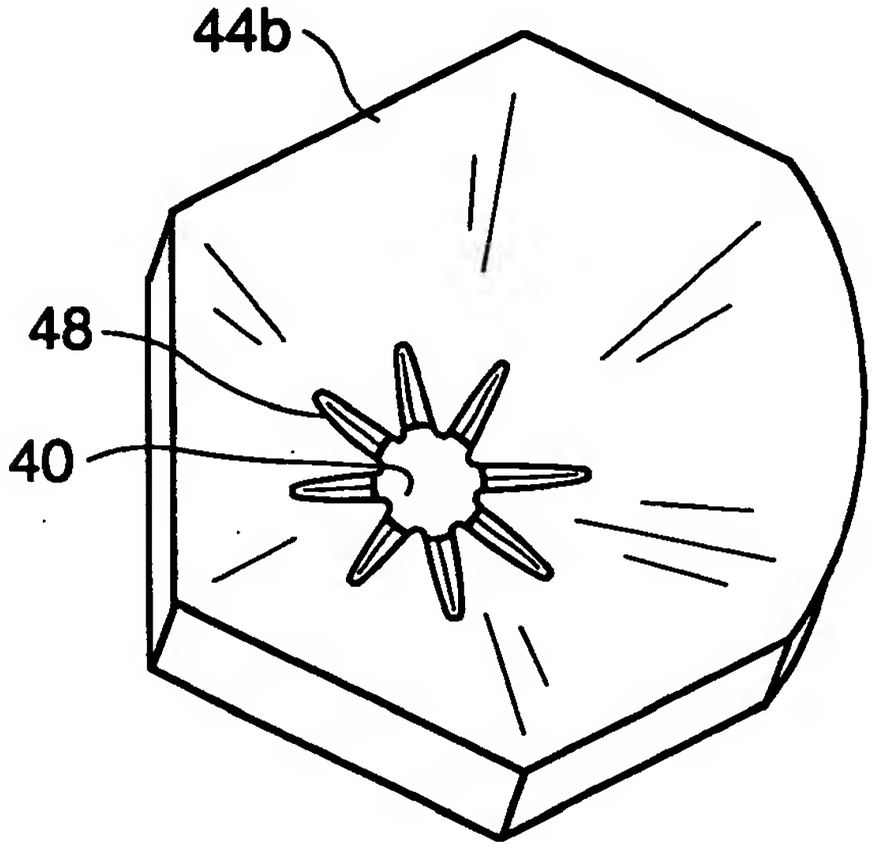

FIG. 9B

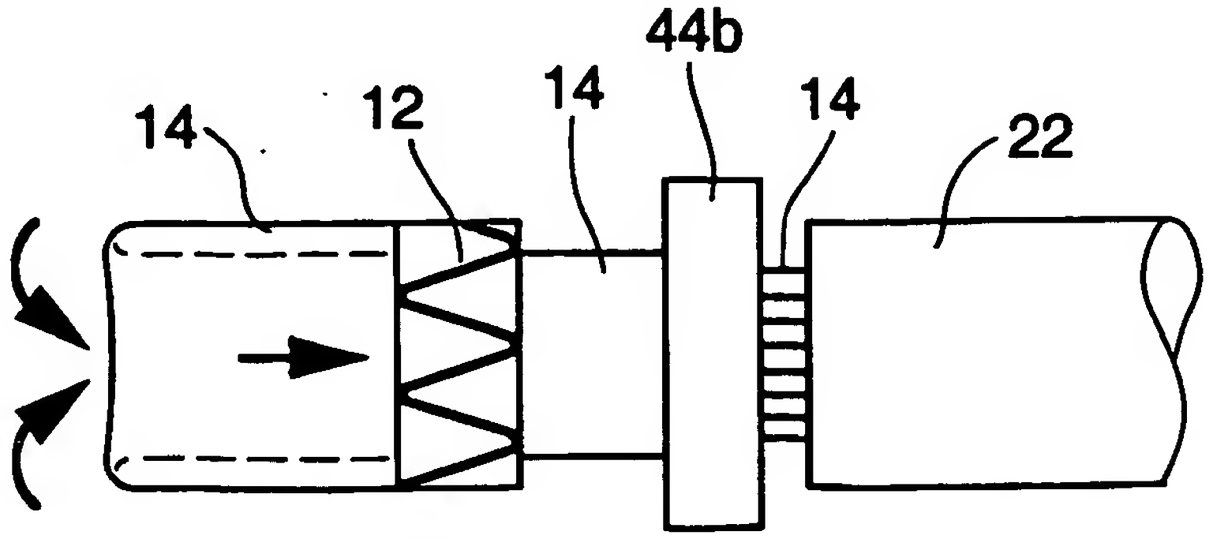

FIG. 9C

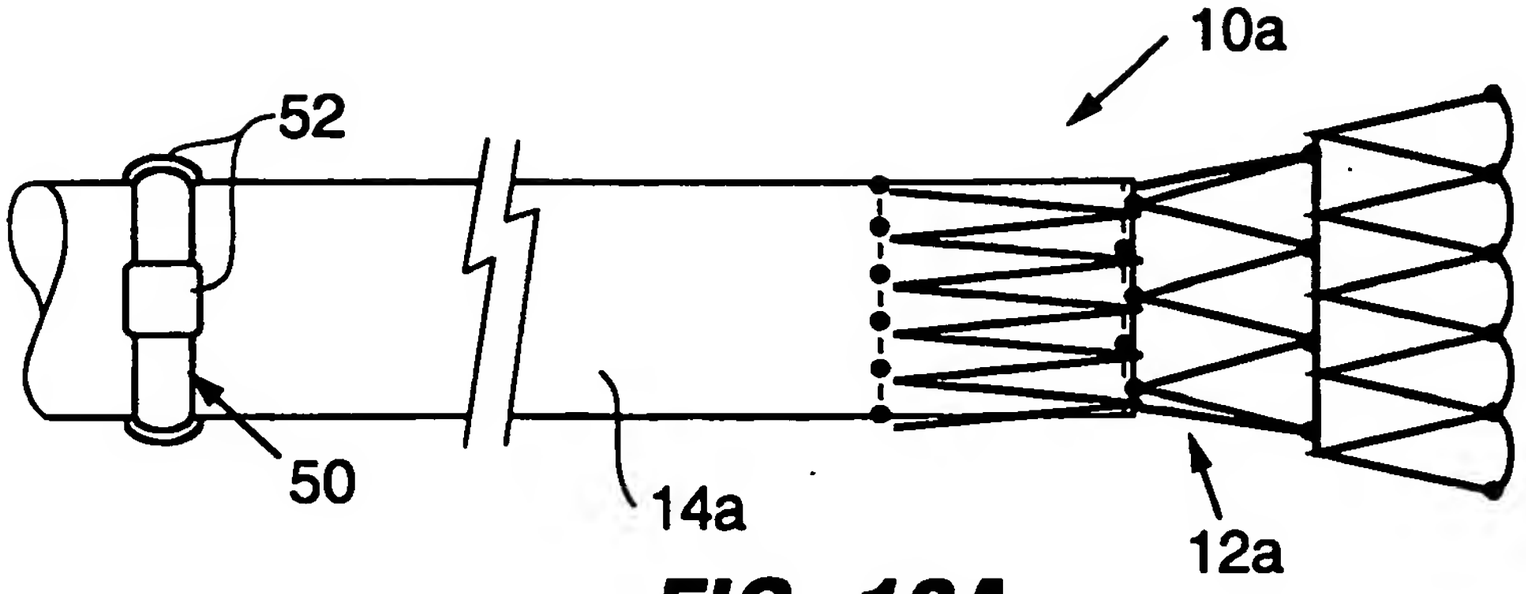

FIG. 10A

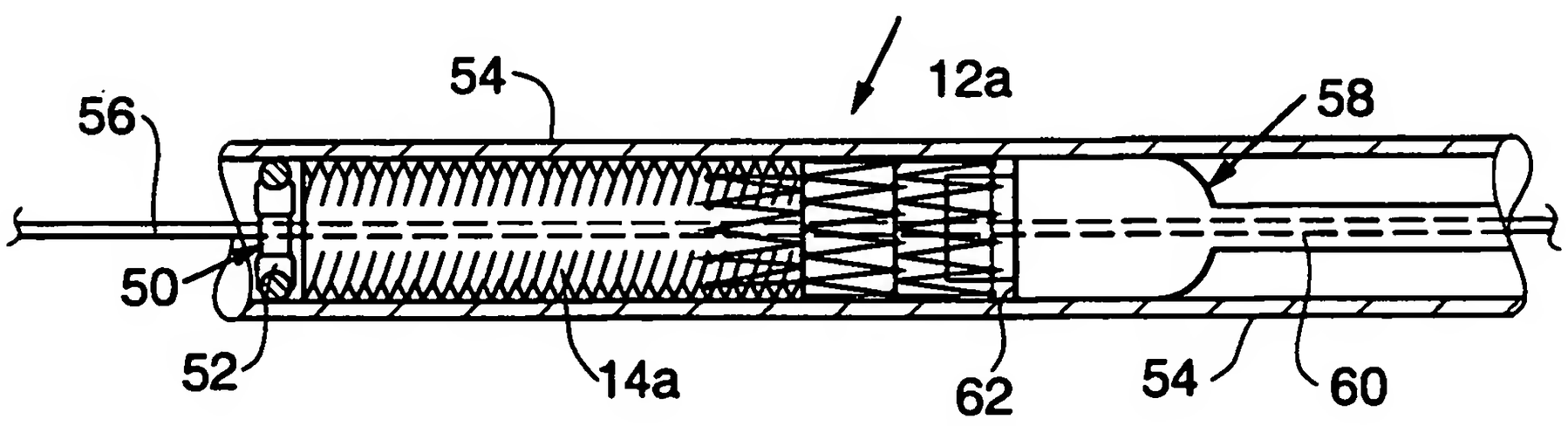

FIG. 10B

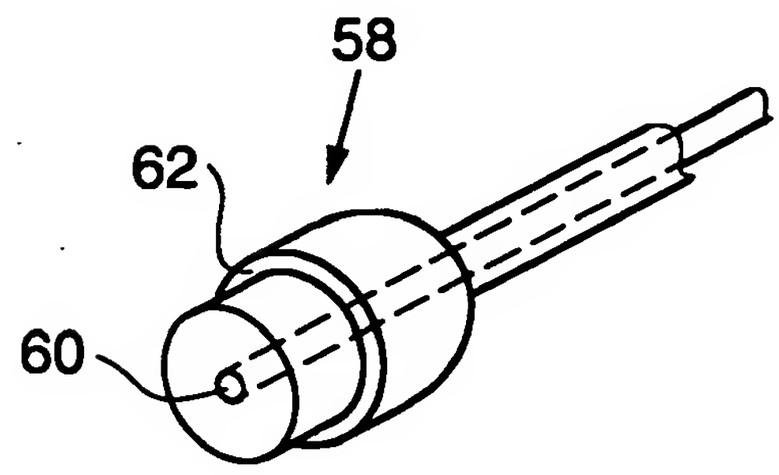

FIG. 10C

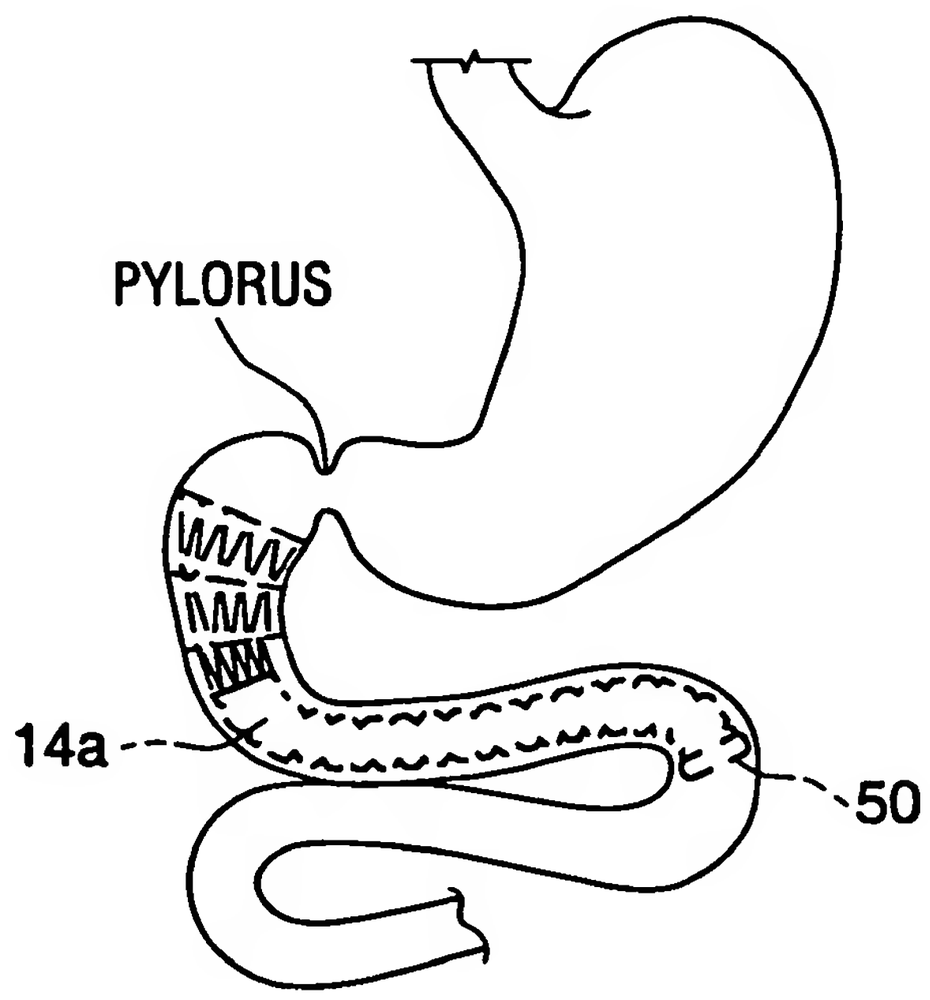

FIG. 10D

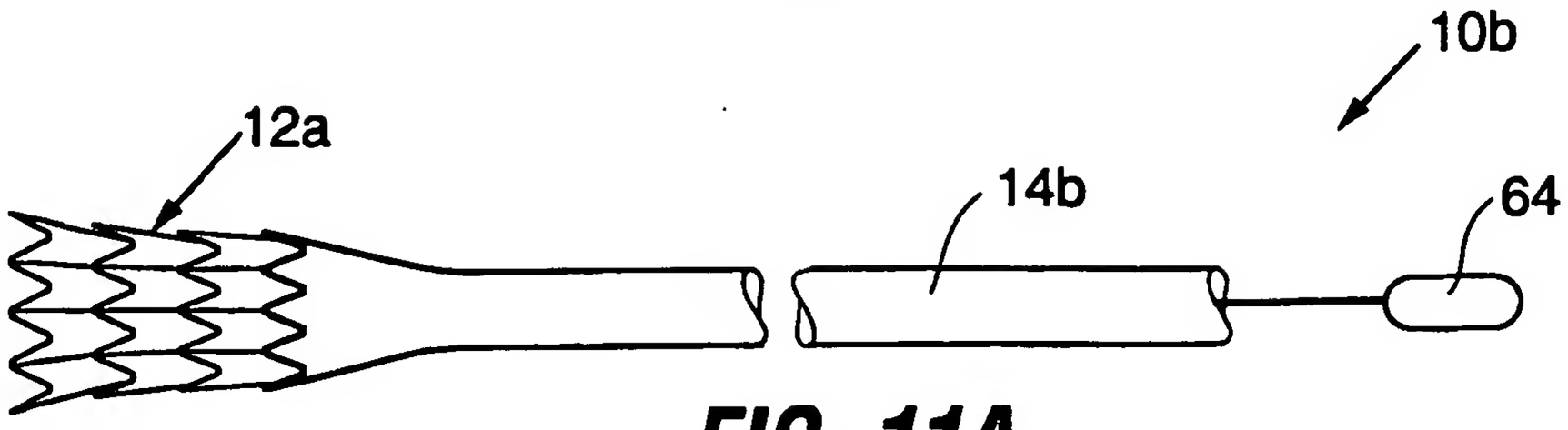

FIG. 11A

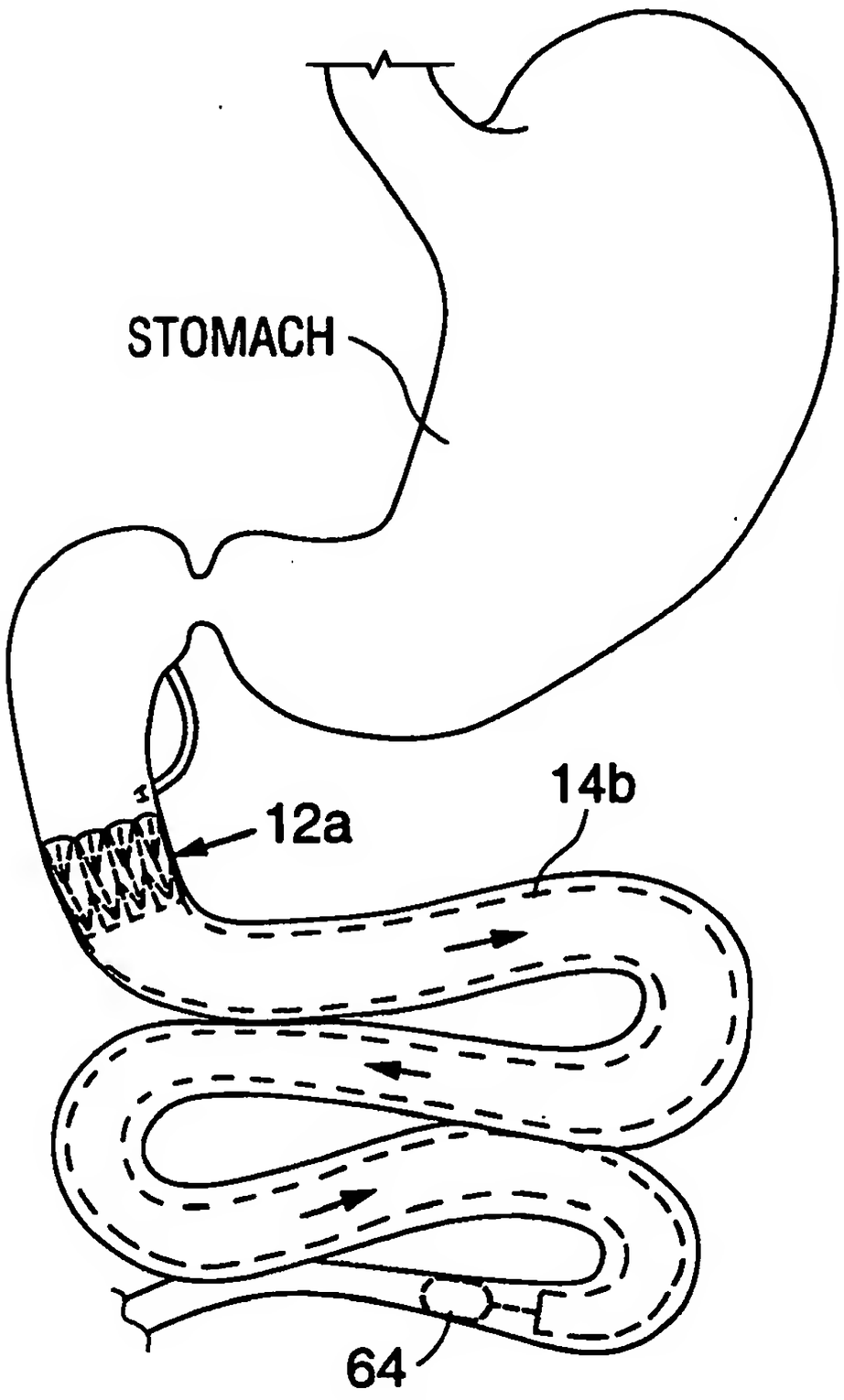

FIG. 11B

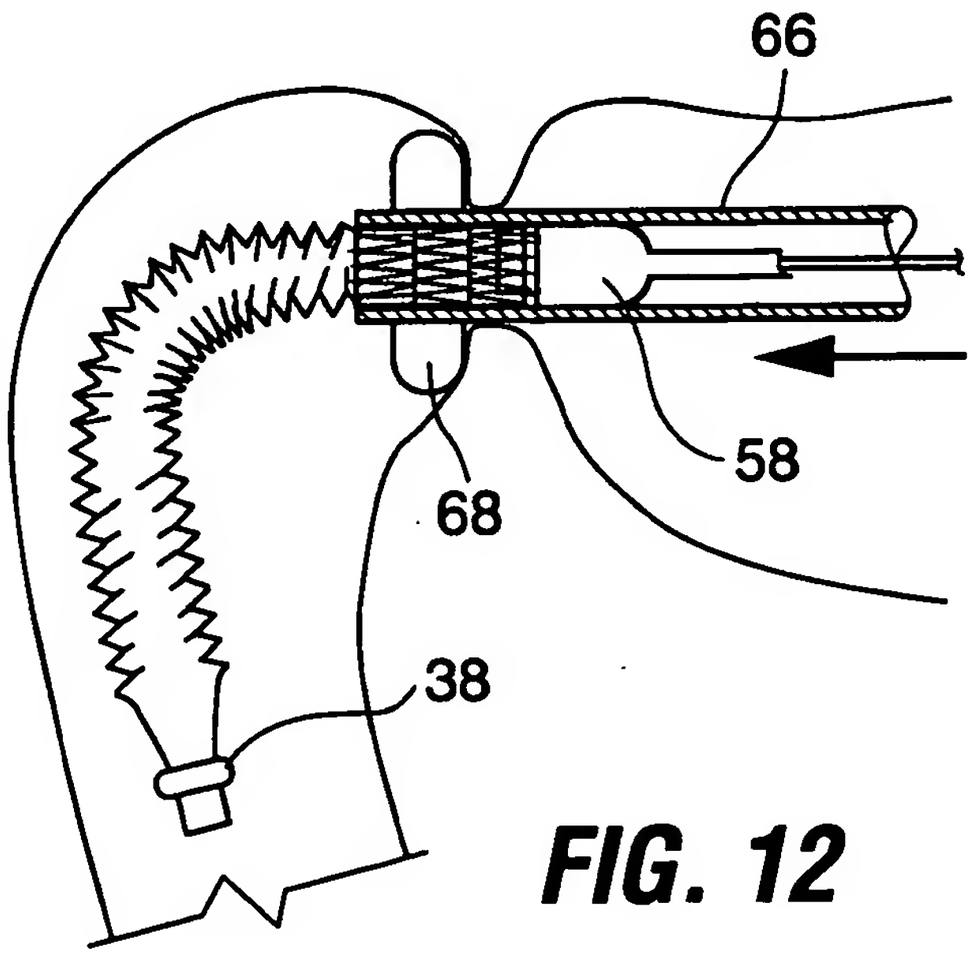

FIG. 12

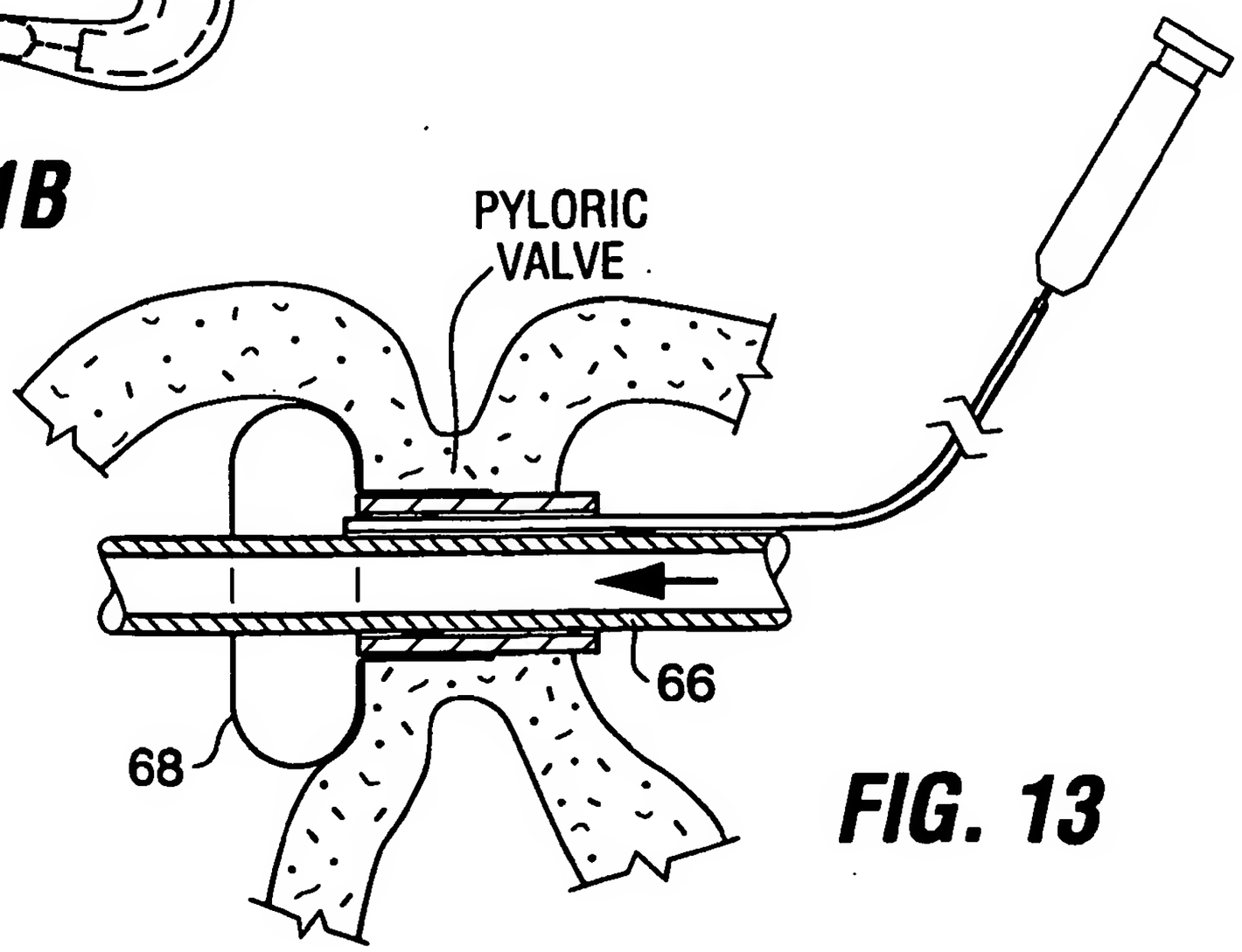

FIG. 13

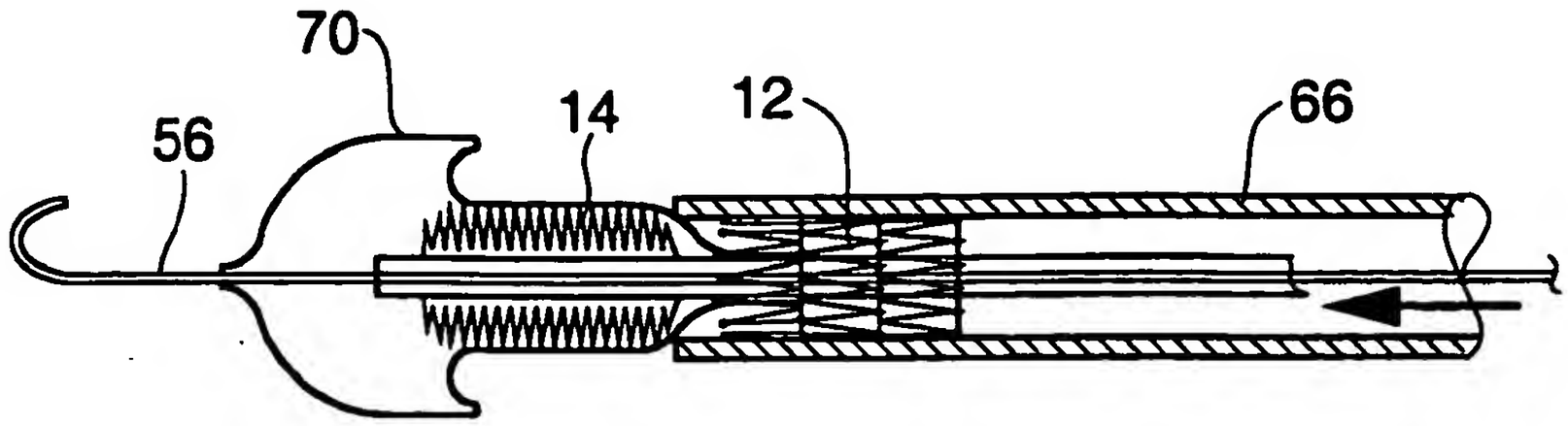

FIG. 14A

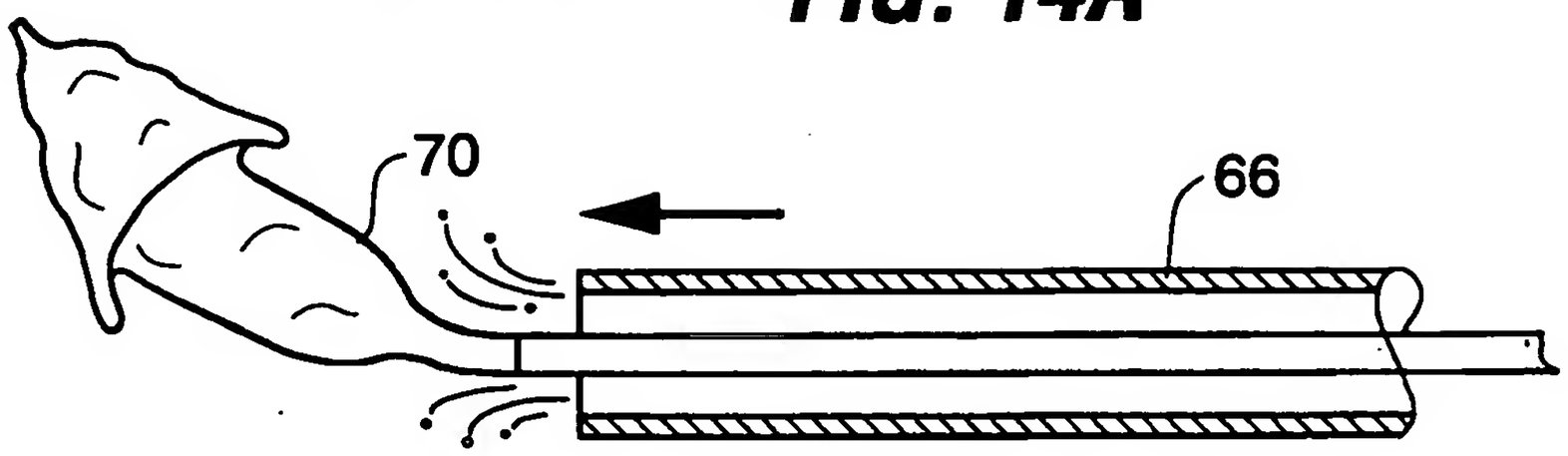

FIG. 14B

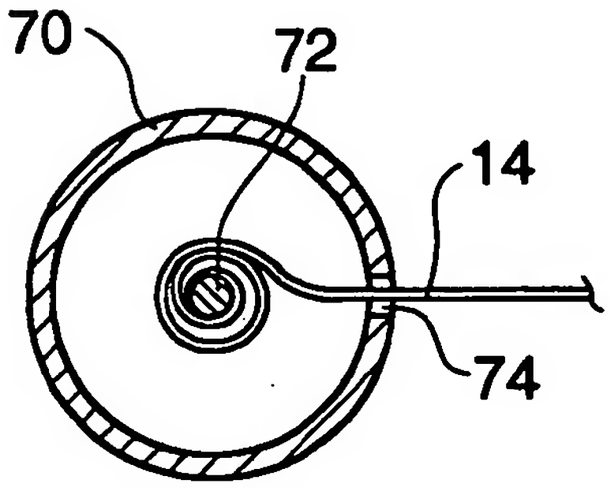

FIG. 15A

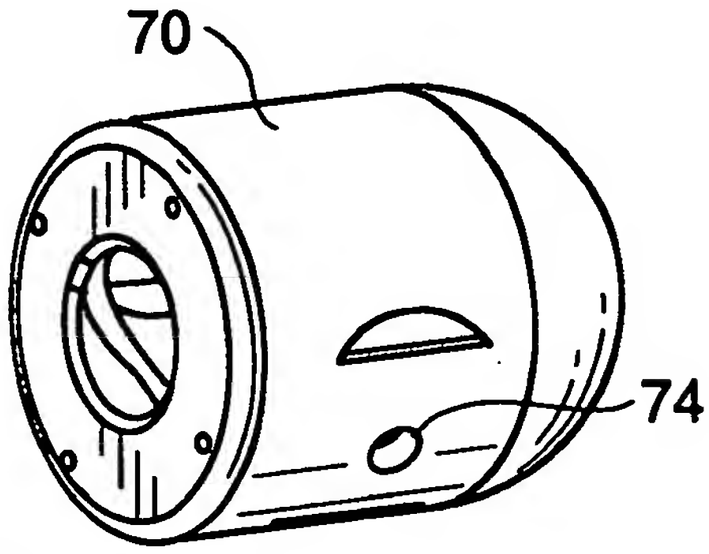

FIG. 15B

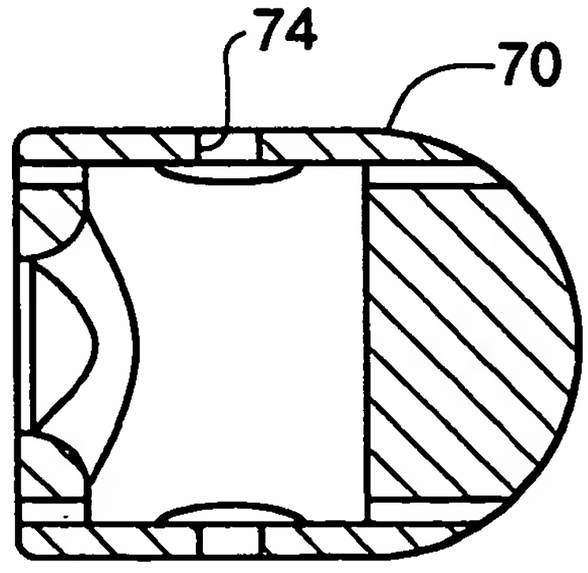

FIG. 15C

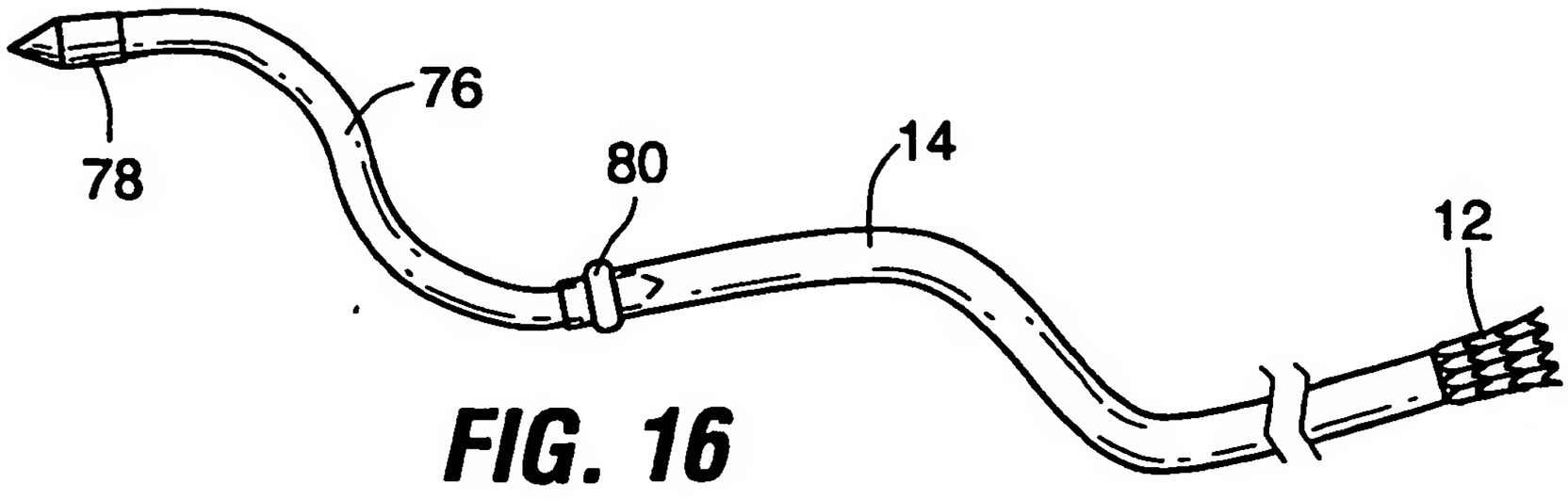

FIG. 16

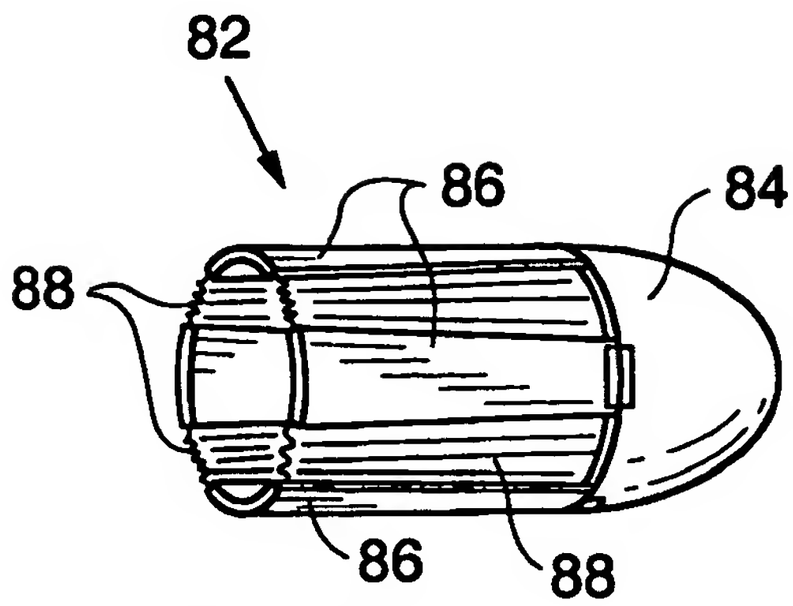

FIG. 17

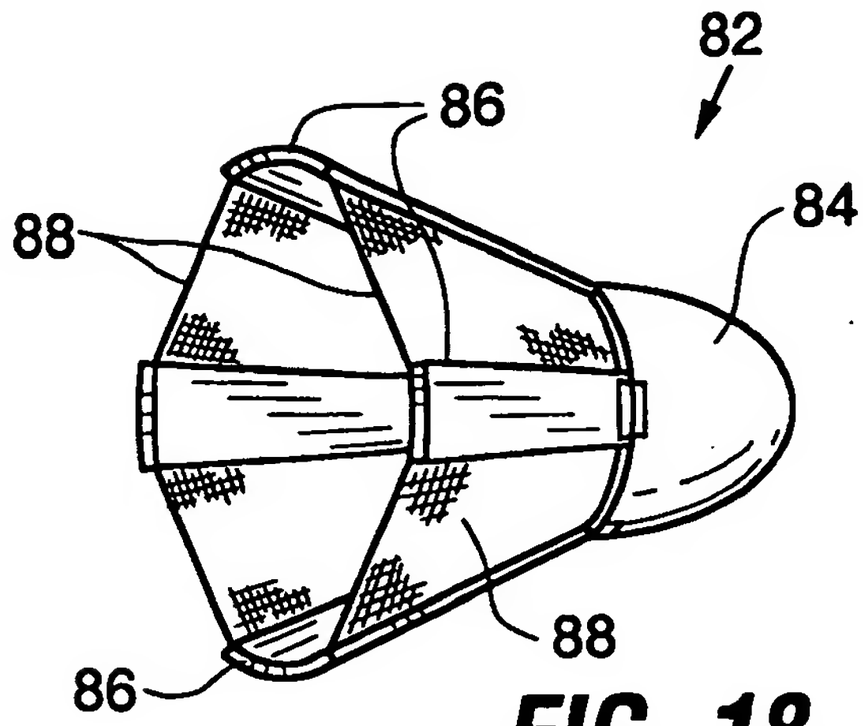

FIG. 18

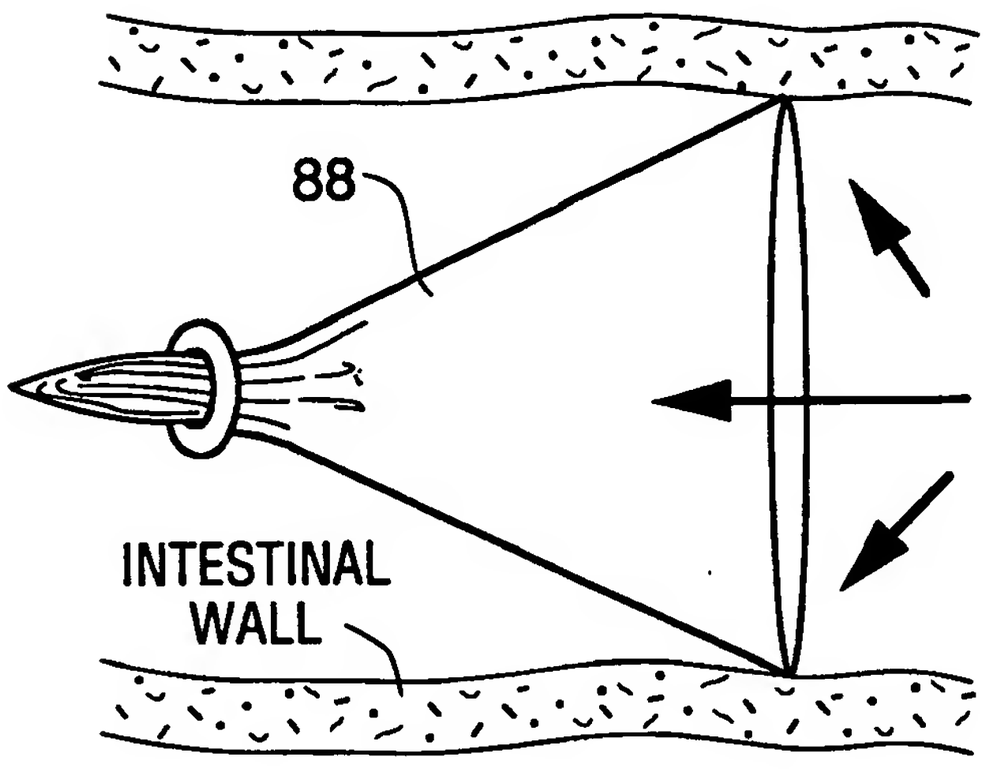

FIG. 19

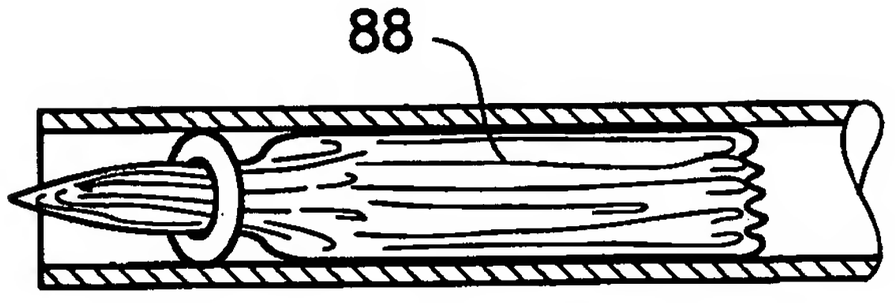

FIG. 20

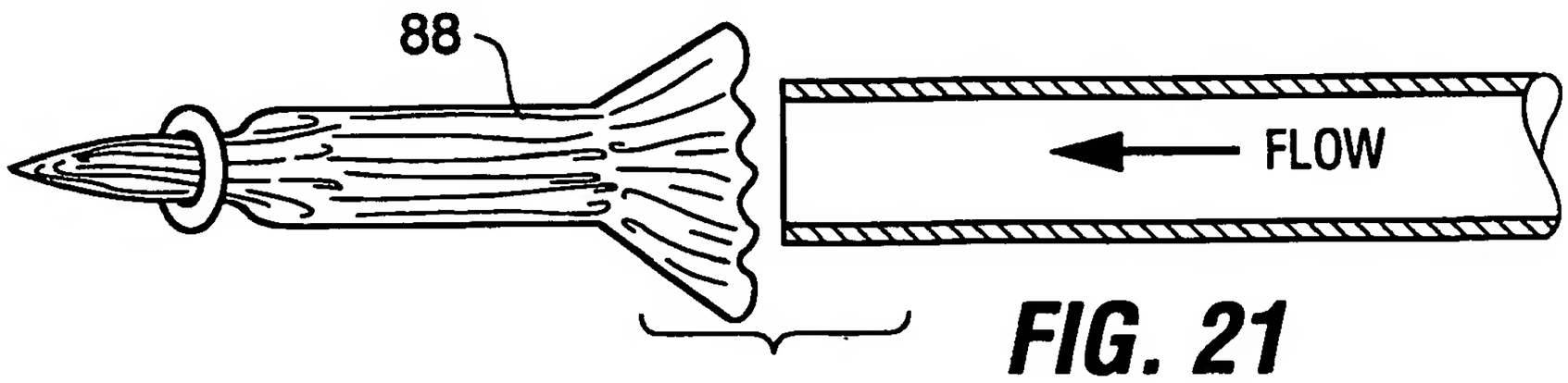

FIG. 21

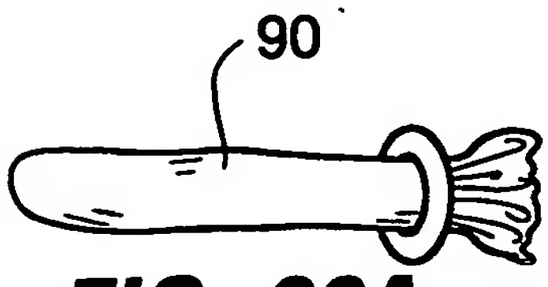

FIG. 22A

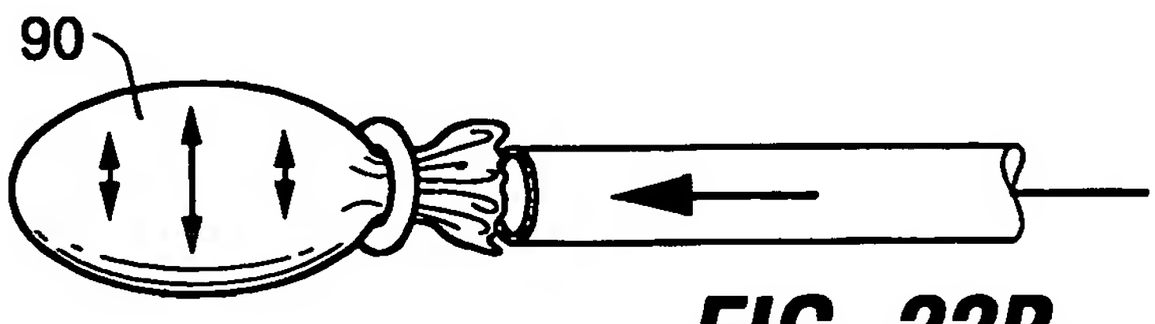

FIG. 22B

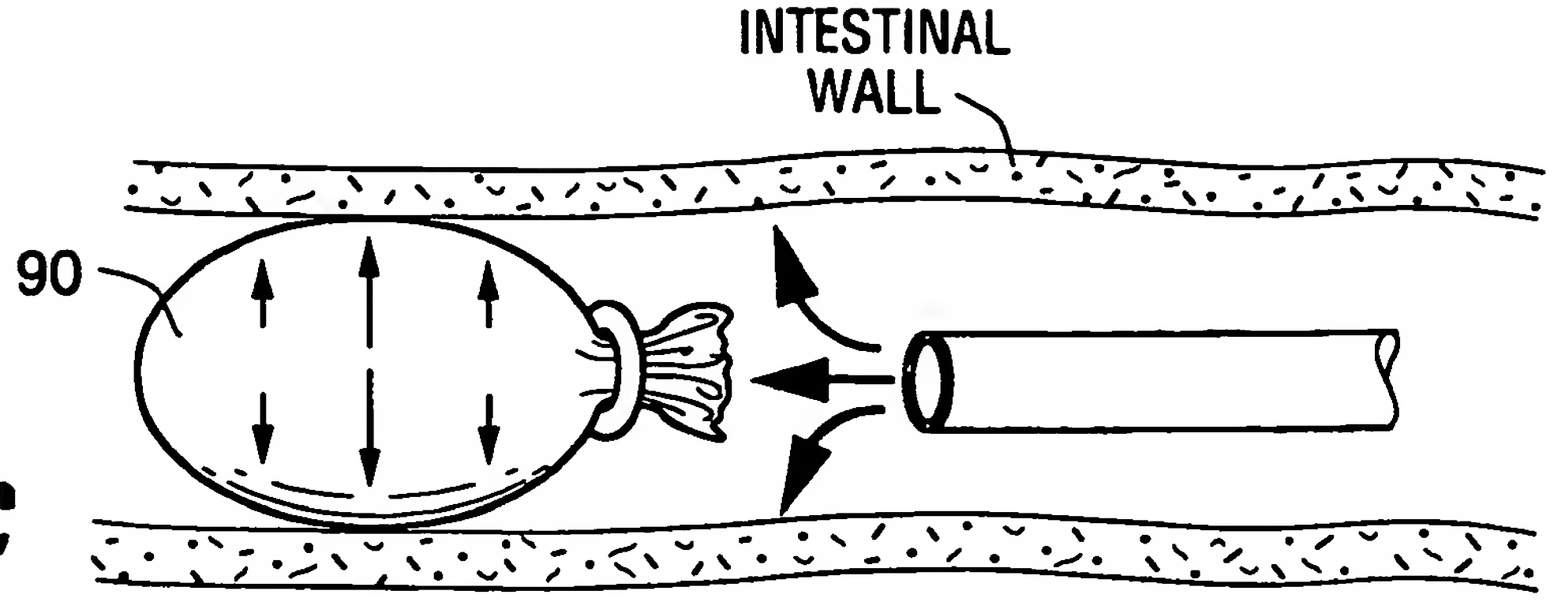

FIG. 22C

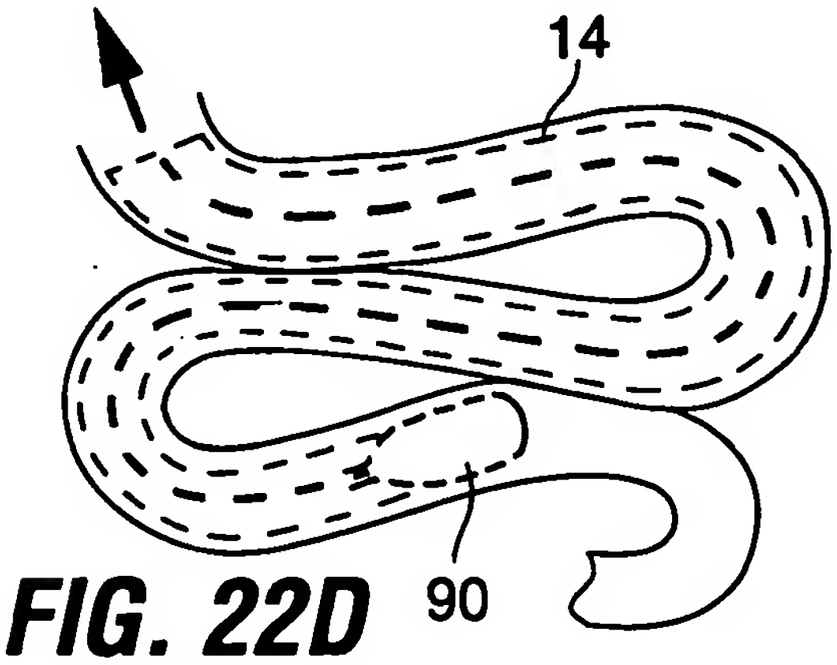

FIG. 22D

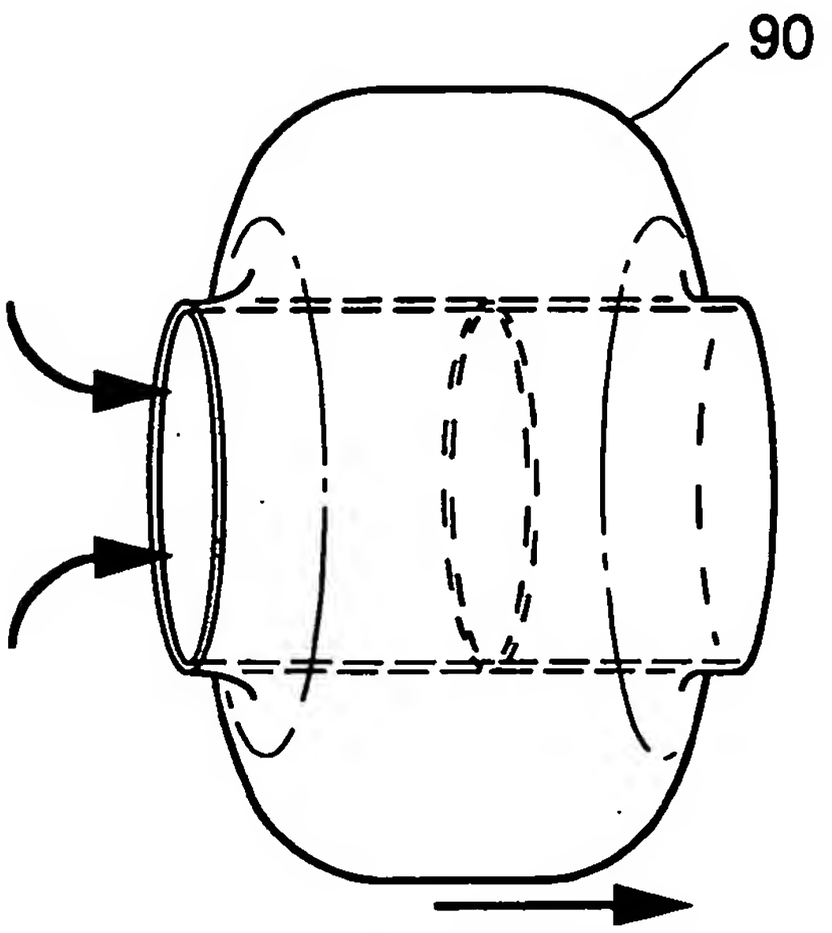

FIG. 23A

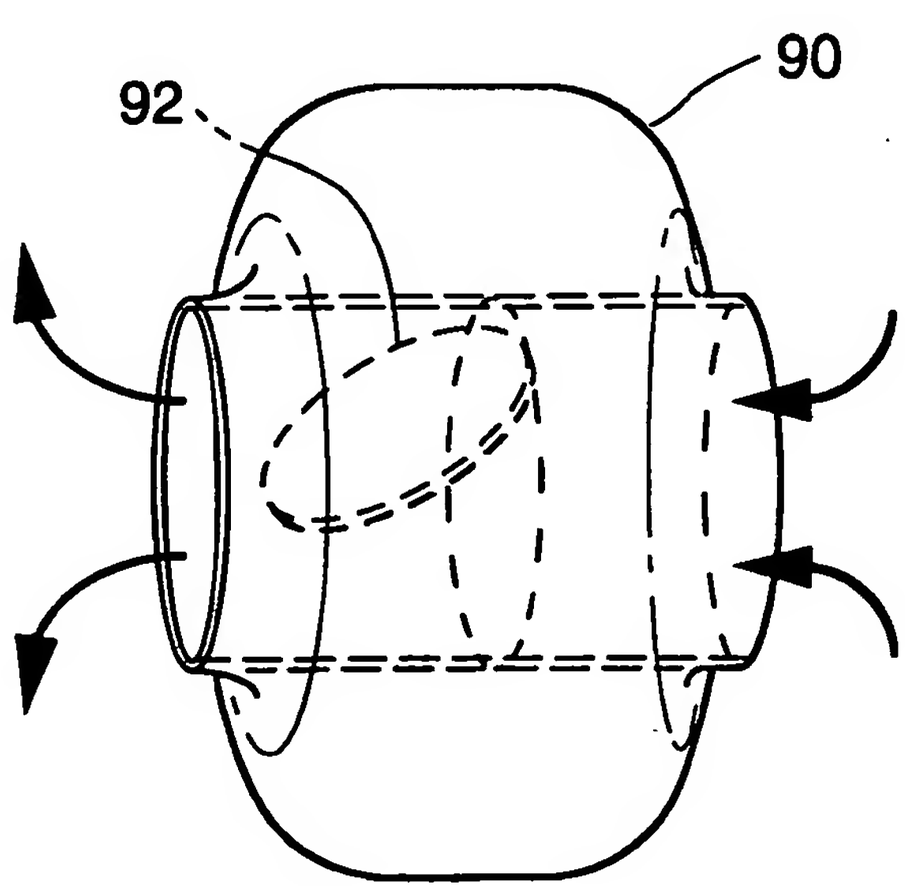

FIG. 23B

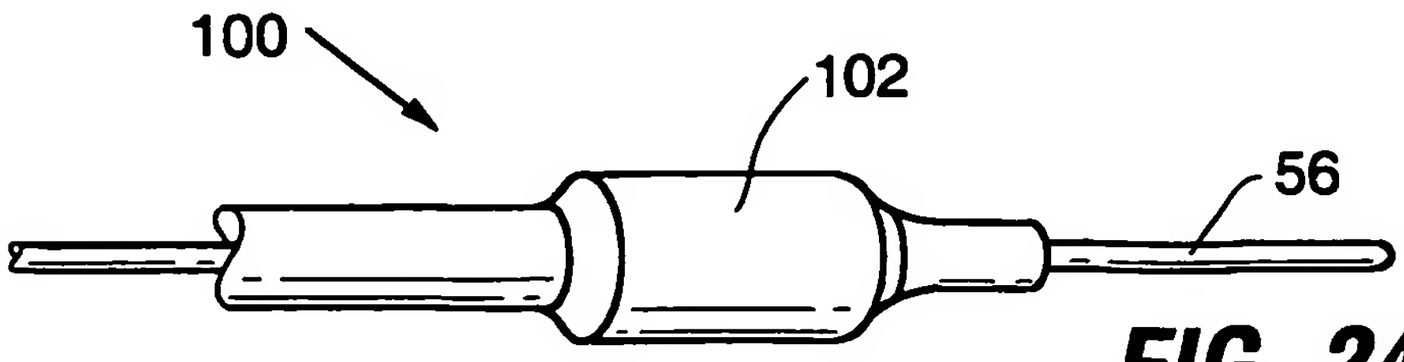

FIG. 24A

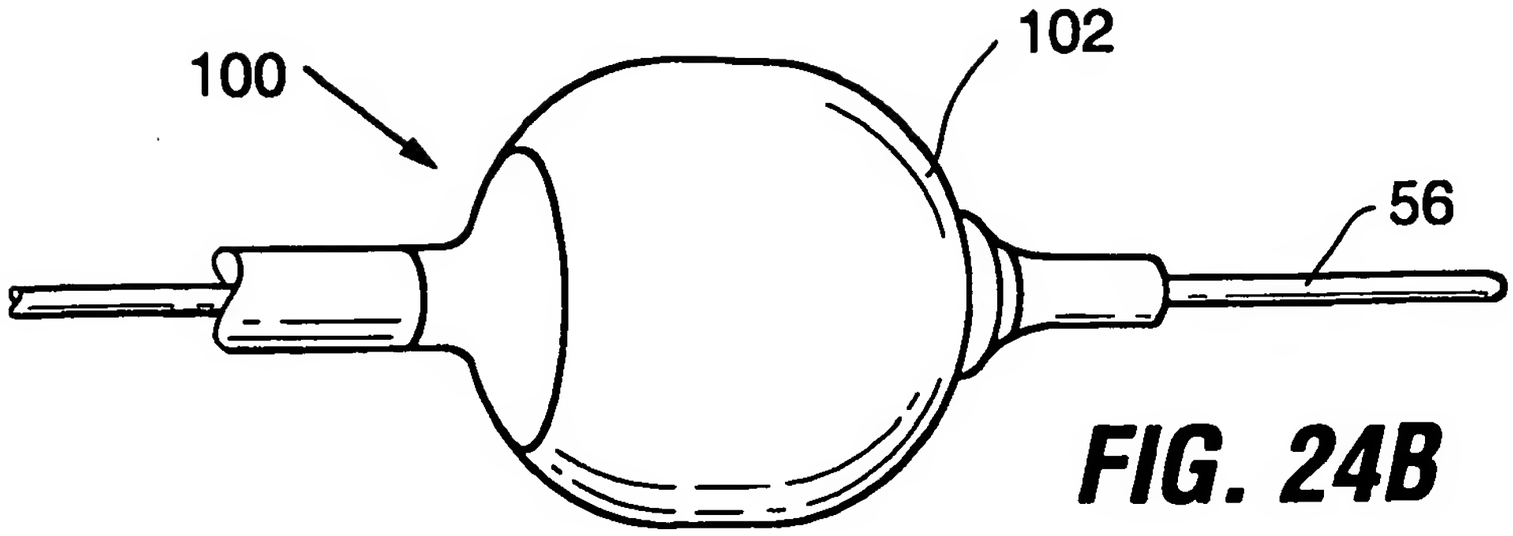

FIG. 24B

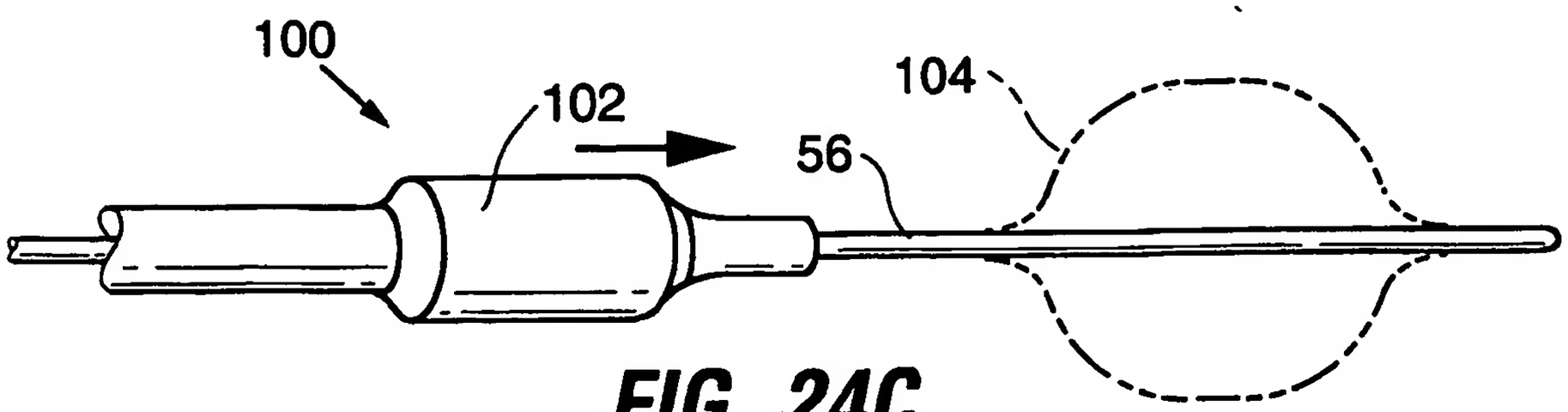

FIG. 24C

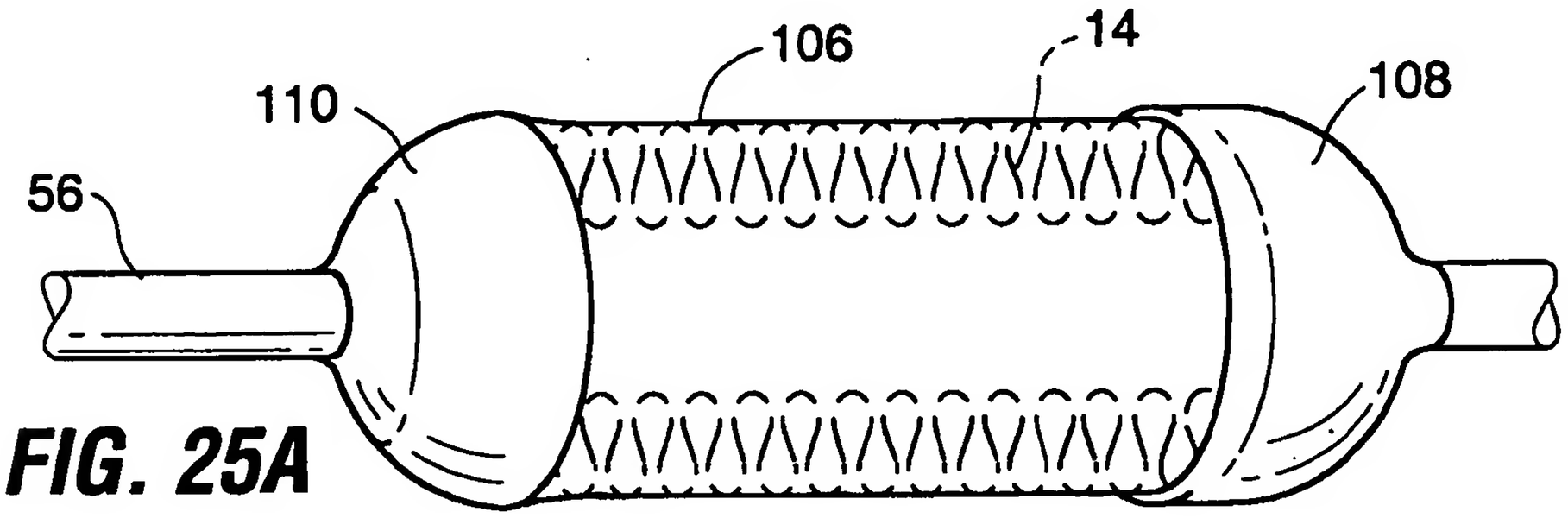

FIG. 25A

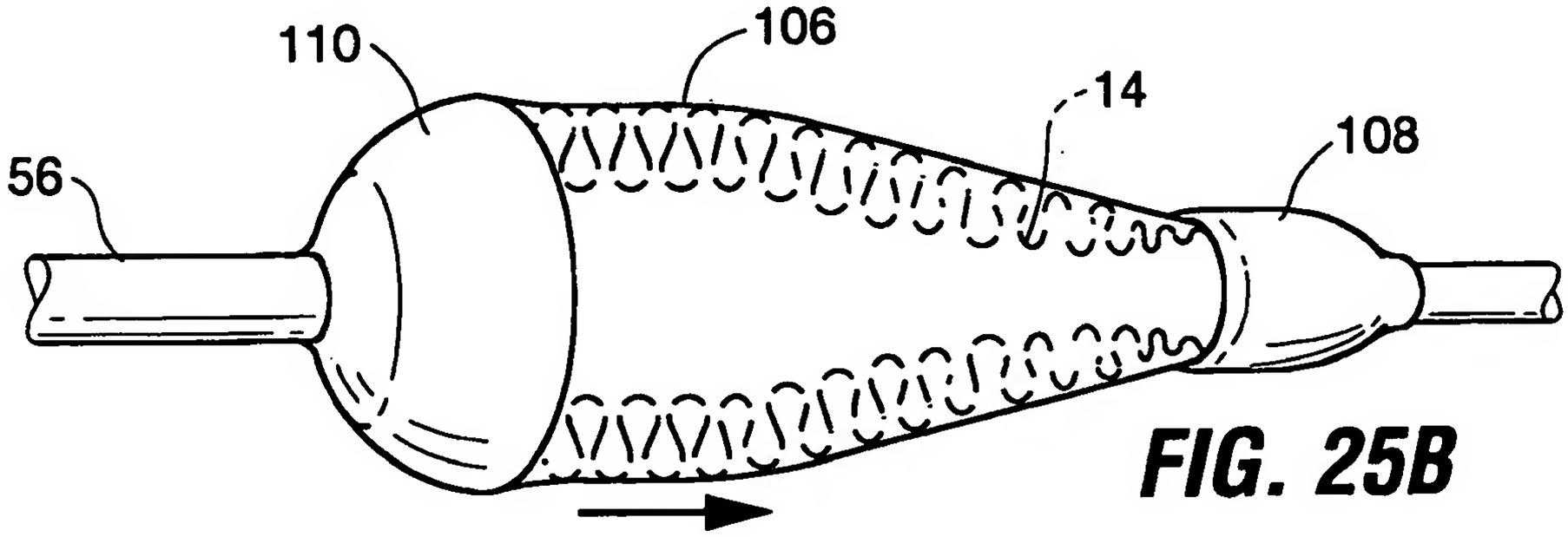

FIG. 25B

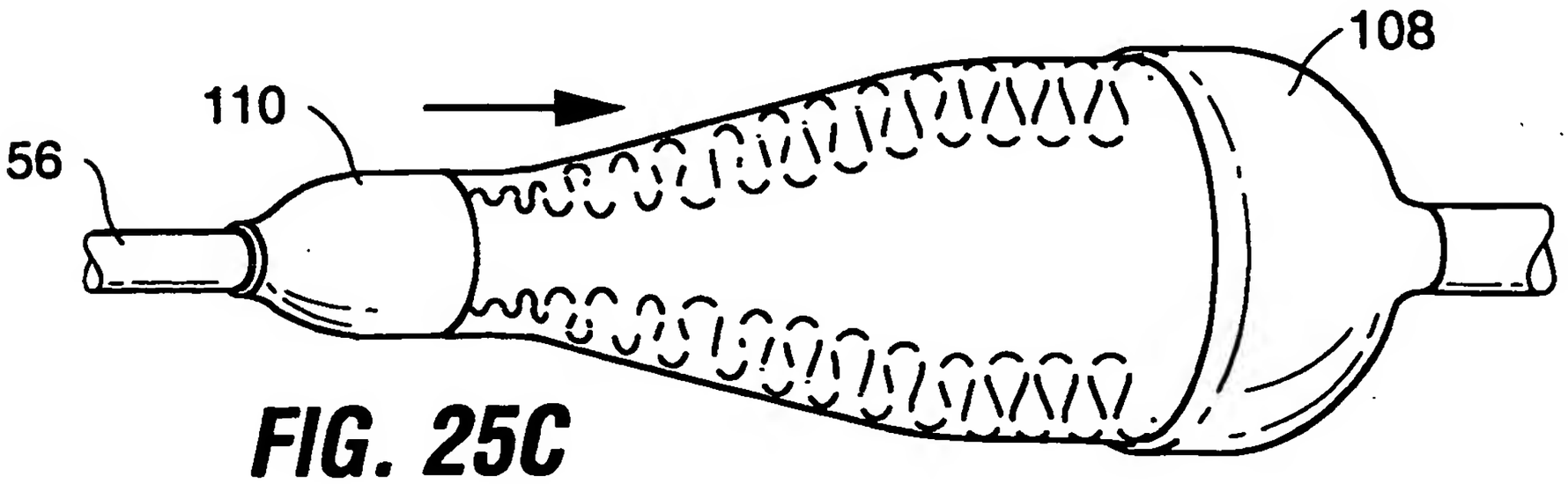

FIG. 25C

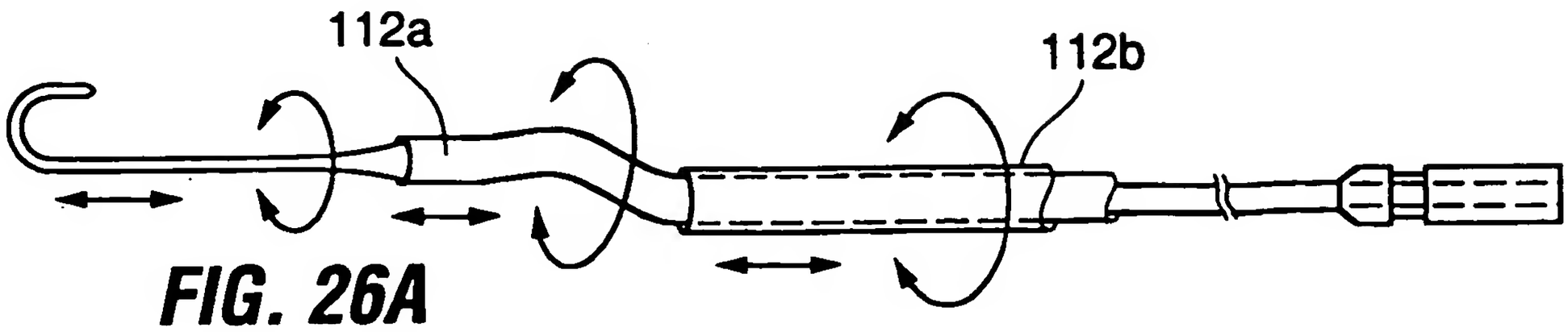

FIG. 26A

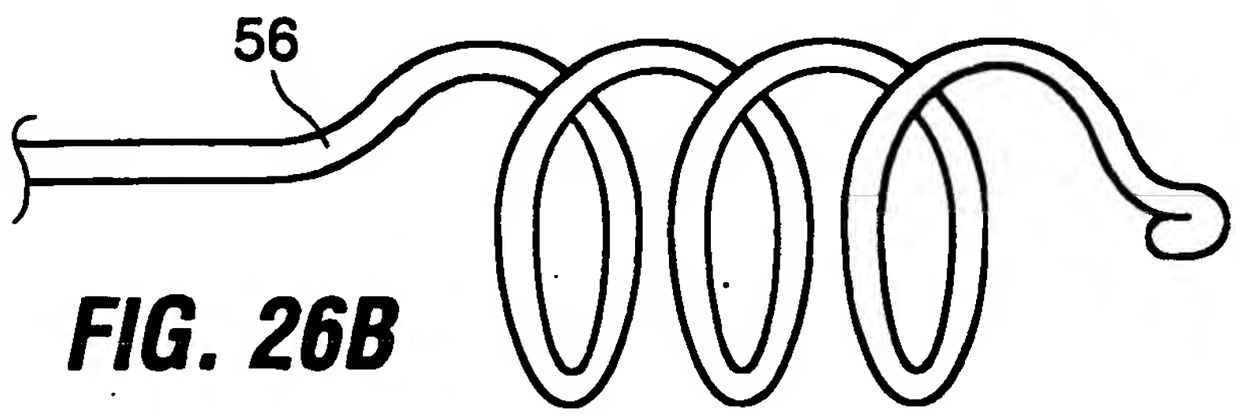

FIG. 26B

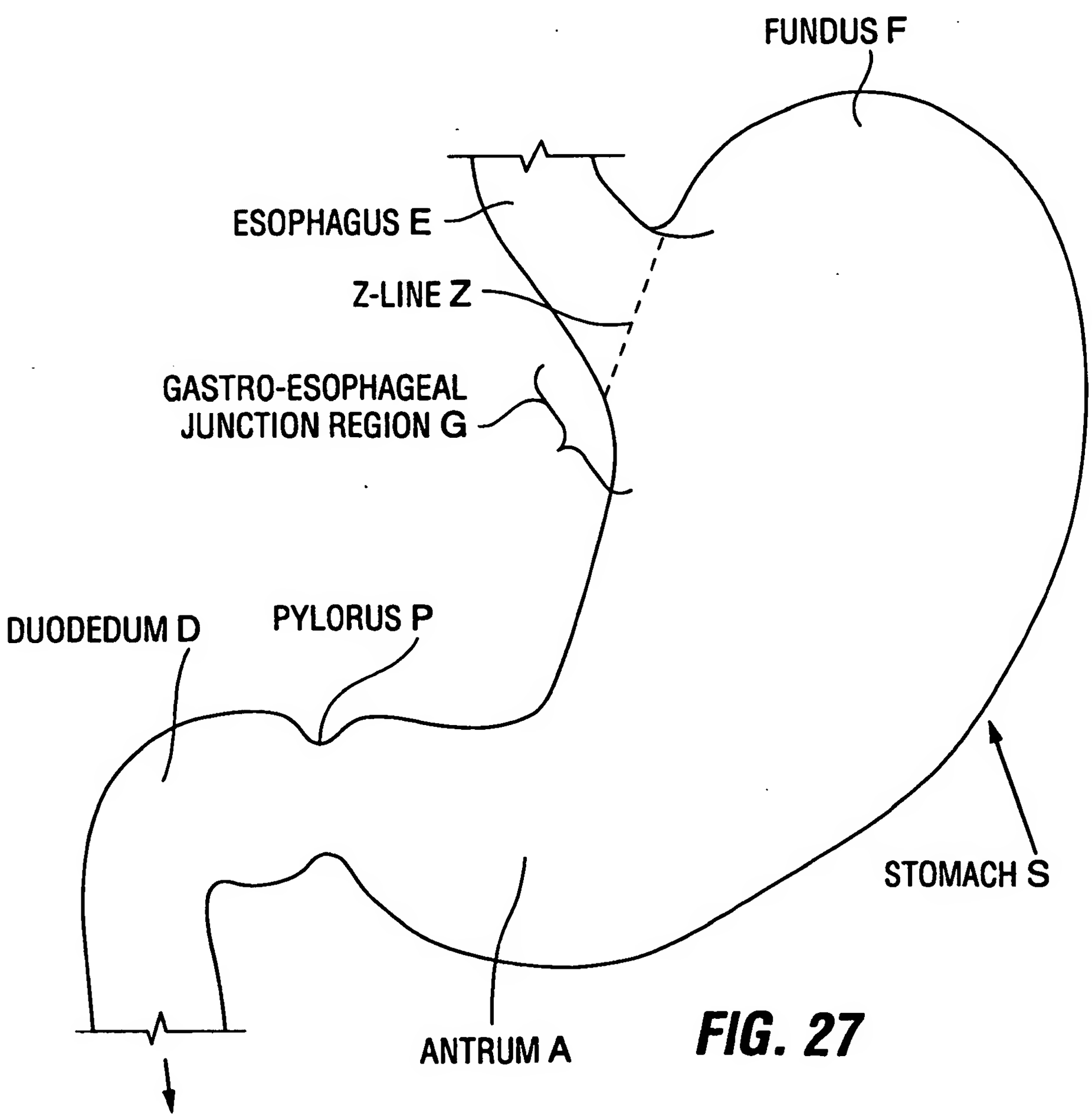

FIG. 27

INTERNATIONAL SEARCH REPORT

International application No
PCT/US2007/019227

A. CLASSIFICATION OF SUBJECT MATTER
INV. A61F2/04

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)
A61F

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)
EPO-Internal

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	WO 2006/016894 A (GI DYNAMICS INC [US]; LEVINE ANDY H [US]; MELANSON DAVID A [US]; LAMPO) 16 February 2006 (2006-02-16) page 9, line 11 - line 26 page 24, line 29 - page 26, line 13	1-7,9-11
Y		8
Y	WO 2005/096991 A (MEDEVERT LTD [GB]; YOUNG ANTONY JOHN [GB]) 20 October 2005 (2005-10-20) page 3, line 26 - line 33	8
X	US 2005/049718 A1 (DANN MITCHELL [US] ET AL) 3 March 2005 (2005-03-03) paragraph [0129] - paragraph [0130]	1-6,9-11

☐ Further documents are listed in the continuation of Box C.

☒ See patent family annex.

* Special categories of cited documents :

"A" document defining the general state of the art which is not considered to be of particular relevance

"E" earlier document but published on or after the international filing date

"L" document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)

"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

"T" later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention

"X" document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone

"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art.

"&" document member of the same patent family

Date of the actual completion of the international search	Date of mailing of the international search report
11 February 2008	20/02/2008

Name and mailing address of the ISA/	Authorized officer
European Patent Office, P.B. 5818 Patentlaan 2 NL – 2280 HV Rijswijk Tel. (+31–70) 340–2040, Tx. 31 651 epo nl, Fax: (+31–70) 340–3016	Mary, Céline

INTERNATIONAL SEARCH REPORT

International application No.
PCT/US2007/019227

Box No. II Observations where certain claims were found unsearchable (Continuation of Item 2 of first sheet)

This international search report has not been established in respect of certain claims under Article 17(2)(a) for the following reasons:

1. [X] Claims Nos.: 12-20
because they relate to subject matter not required to be searched by this Authority, namely:

Rule 39.1(iv) PCT - Method for treatment of the human or animal body by surgery

2. [ ] Claims Nos.:
because they relate to parts of the international application that do not comply with the prescribed requirements to such an extent that no meaningful international search can be carried out, specifically:

3. [ ] Claims Nos.:
because they are dependent claims and are not drafted in accordance with the second and third sentences of Rule 6.4(a).

Box No. III Observations where unity of invention is lacking (Continuation of Item 3 of first sheet)

This International Searching Authority found multiple inventions in this international application, as follows:

1. [ ] As all required additional search fees were timely paid by the applicant, this international search report covers allsearchable claims.

2. [ ] As all searchable claims could be searched without effort justifying an additional fees, this Authority did not invite payment of additional fees.

3. [ ] As only some of the required additional search fees were timely paid by the applicant, this international search reportcovers only those claims for which fees were paid, specifically claims Nos.:

4. [ ] No required additional search fees were timely paid by the applicant. Consequently, this international search report is restricted to the invention first mentioned in the claims; it is covered by claims Nos.:

Remark on Protest

[ ] The additional search fees were accompanied by the applicant's protest and, where applicable, the payment of a protest fee.

[ ] The additional search fees were accompanied by the applicant's protest but the applicable protest fee was not paid within the time limit specified in the invitation.

[ ] No protest accompanied the payment of additional search fees.

INTERNATIONAL SEARCH REPORT

Information on patent family members

International application No
PCT/US2007/019227

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
WO 2006016894 A	16-02-2006	EP 1768618 A1	04-04-2007
WO 2005096991 A	20-10-2005	GB 2413769 A	09-11-2005
US 2005049718 A1	03-03-2005	NONE	